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Healthcare professionals' views on barriers, facilitators and optimisation of care for perinatal anxiety: A qualitative investigation

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Abstract

Background: The experience of pregnancy and having a baby is a time of significant change and transition. One in five perinatal women experience problems with their emotional wellbeing and mental health in this period; adjustment, anxiety and depressive illnesses being most common. Whilst investment in specialist perinatal mental health pathways continues, there is limited understanding of healthcare professionals' views and experiences of these pathways and of support available for women with mild or moderate mental health problems. This study explored healthcare professionals' views on the barriers and facilitators to identification and management of perinatal anxiety, and on how to optimise care pathways.

Methods: In-depth semi-structured interviews were conducted with a purposive sample of healthcare professionals in universal perinatal services (including maternity, primary care, and health-visiting) and specialist (including talking therapies, maternal and perinatal) mental health services. Data were analysed using framework analysis.

Results: Interviews were conducted with 62 healthcare professionals from England and Scotland. 40% of the sample stated they had received no training in perinatal mental health, and 45% reported that they did not use standardised or validated questions or scales when enquiring about mental health. Themes related to barriers, facilitators, and service optimisation are presented for each stage of their care pathway: identification; disclosure; referral and assessment; care and treatment. Recommendations for optimising care included improving mental health education and training to strengthen perinatal healthcare and developing a sustainable perinatal mental health pathway, including for women with mild mental health problems.

Conclusions: Healthcare professionals considered that the healthcare pathway for women with severe mental health problems was clear and well-developed, but that healthcare for women with mild and moderate anxiety and mental health problems was under-developed. Improvements in perinatal mental health education, in mandatory training for healthcare professionals, should be put in place in order to improve care. Increasing the number of staff

and time available to address perinatal mental health is vital but requires additional resources and should be part of long-term strategies for funding.

Contributions to the literature

- A multi-disciplinary view of current healthcare pathways for perinatal anxiety, a common problem which can impact women, their children and families.
 - Perspectives from healthcare professionals, specialised and not specialised in mental health, from across the UK.
 - Healthcare professionals reported there were clear pathways for those with severe disorders. Pathways for mild to moderate distress require further development.
 - We recommend the inclusion of accredited, accessible and funded perinatal mental health training for healthcare professionals to optimise care.
- Long-term strategic investment is required to increase the number and balance of healthcare professionals supporting women with perinatal anxiety.

Key Words

Care Pathway; Perinatal Anxiety; Healthcare Professionals; Barriers and Facilitators; Assessment; Treatment; Training

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Background

The experience of pregnancy and becoming a parent is a time of great change and transition. In this research we focused on the experience of anxiety in women during the perinatal period (pregnancy and the first year of a baby's life [1]). One in five women experiences perinatal anxiety, with symptoms higher in early pregnancy although individual variation exists and evidence is inconsistent [2]. Feeling anxious can be a natural, healthy response to change, therefore it is unsurprising that women are more likely to be anxious whilst pregnancy is being confirmed and this new life stage is being emotionally processed. Newborn babies elicit anxiety in their mothers to make sure their needs for survival are met; the first days and weeks are emotionally intense for new mothers and feeling anxious is often a natural part of this. However, symptoms of anxiety can range from mild and moderate symptoms, such as fear, tension and worry, through to anxiety disorders such as generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder and tokophobia (severe fear of childbirth) [2]. Anxiety can be impacted by social, psychological and sociodemographic factors and life events [3] and ongoing perinatal anxiety can impact the physical and psychological health of women, their infants and families, including a greater risk of postnatal mental health difficulties for both mother and partner [4], increased risk of preterm birth and low birthweight [5] and impaired infant development [6]. Reliance on diagnoses of perinatal anxiety is challenging: healthcare

professionals (HCPs) focus on depression [7]; have limited time in routine healthcare appointments [8]; and not all women needing support reach clinical threshold or need specialist treatment. Therefore, it is important to consider the identification and management of perinatal anxiety.

Reviews of barriers and facilitators to implementing [9] and accessing [10] support for perinatal mental health (PMH) have identified factors relating to women and HCPs. Barriers include HCPs being unfamiliar with perinatal anxiety, having limited awareness of diagnostic presentations of anxiety, and little collaboration between healthcare disciplines [8].

Organisational barriers include lack of mental health services for women's referral [11,12] and lack of training, knowledge and skills in PMH, particularly perinatal anxiety, for example among public health nurses [11] and midwives in the United Kingdom (UK) [13] and abroad [14,15]. Decision-making about funding services may result in limited opportunities for HCPs to identify women with mental health problems or offer intervention [13,16].

Perinatal mental health problems that are not treated effectively cost society £8.1 billion every year, with the annual cost to the National Health Service (NHS) estimated at £1.2 billion [17]; Since anxiety is highly prevalent, some of this cost is likely attributable to perinatal anxiety. In the UK there has been significant investment in PMH services since 2016 [18,19] including specialist PMH services and maternal mental health services for women experiencing complex mental health difficulties directly arising from their maternity experience [20]. However, at the same time there have been fewer resources for universal services, for example an estimated 40% reduction in UK health visitors since 2015 [21]. Descriptions of HCP roles and the typical services and appointments they provide are given in Figure 1.

Figure 1: Services and HCPs in Perinatal Anxiety Pathway

The NHS in England [22] has five perinatal pathwaysⁱ providing evidenced-based care focussed on those with complex or severe mental health problems: preconception advice; specialist assessment; emergency assessment; psychological interventions; and inpatient care. NHS Scotland have similar pathways [23], including an additional pathway for psychological interventions for mild or moderate mental health problems. Pathways and services for mild to moderate PMH problems remain under-developed [24]. HCPs have previously identified that improvements in perinatal anxiety care could come from ensuring every contact is utilised to support well-being [8]; consistent, routine assessment of mental health [25,26]; appropriate referral to specialist services [27]; and the adoption of an individualised approach to management of distress [8].

Reviews have synthesised evidence on barriers to PMH assessment and management based on perspectives of midwives [26,28] and General Practitioners (GPs) [12,29]. Little primary research exists which considers views of other HCPs. Silverwood and colleagues [30] considered barriers from the perspective of 23 HCPs, GPs, midwives, and health visitors, from one region in England. This study was therefore able to draw out the variability in understanding and care for perinatal anxiety across these professions. No studies have assessed perceived barriers across the diverse range of HCPs involved with PMH and across the UK.

Methods

Aims, Design and Setting

This study aimed to elicit HCPs' views on barriers and facilitators to identifying and managing perinatal anxiety amongst primary-, maternity-, and secondary- care providers working with perinatal women and how services could be optimised to improve care.

A qualitative design using individual semi-structured interviews, this study was part of MAP Alliance funded by the NIHR (NIHR133727) [31] and follows the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist to support comprehensive study reporting [32].

Ethics

Ethical approval was gained from City, University of London School of Health Sciences Research Ethics Committee (ETH2122-1507) and Health Research Authority (22/HRA/4584).

Participants

HCPs were eligible to take part if they worked in, or commissioned, perinatal healthcare services. Purposive sampling guided by a matrix ensured representation of different: professional roles (including midwives, obstetricians, health-visitors, GPs, psychiatrists and psychologists); levels of experience; services (universal and specialist perinatal and maternity care and commissioning); and regions (Clinical Research Networks (CRNs) in England; Primary Care Networks (PCNs) in Scotland).

HCPs were initially contacted from sites involved in the MAP Study [2] and expanded to other CRNs, resulting in ten recruitment sites (see Table 1). The target sample size was 60 to ensure the different factors were represented. Potential participants were identified by staff at CRN and NHS sites between January and June 2023 and emailed details of the study (participant information sheet) and a link to the online consent form. Participants who consented completed a demographic form and were contacted to arrange a convenient interview date, time, and format.

Table 1 – Healthcare Professional Sample Information

Sample Information	<i>N (%)</i>
Recruitment Site CRN/PCN	
<i>England</i>	<i>54 (87.1)</i>
East Midlands CRN	4 (6.5)

Kent, Surrey and Sussex CRN	4 (6.5)
North Central London Research Network CRN (NOCLOR)	5 (8.1)
North Thames CRN	4 (6.5)
North East and North Cumbria CRN	4 (6.5)
Wessex CRN	8 (12.9)
West Midlands CRN	12 (19.4)
South Thames CRN	4 (6.5)
<i>Scotland</i>	8 (12.9)
Rural PCNs	3 (4.8)
Urban PCNs	5 (8.1)
Ethnicity	
Asian	4 (6.5)
Asian British	3 (4.8)
Black	3 (4.8)
British	5 (8.1)
White	3 (4.8)
White British	32 (51.6)
White Other	6 (9.7)
Other	2 (3.2)
Unknown	4 (6.5)
Current profession	
Commissioning/Management	3 (4.8)
Commissioner	1 (1.6)
Service Manager	2 (3.2)
General Practice	11 (17.7)
General Practitioner (GP)	10 (16.1)
Practice Nurse	1 (1.6)

Health Visiting	10 (16.1)
Community Health Nurse	1 (1.6)
Health Visitor	7 (11.3)
Specialist Health Visitor	2 (3.2)
Maternity Services	20 (32.3)
Consultant Midwife	1 (1.6)
Community Midwife	1 (1.6)
Hospital Midwife	5 (8.1)
Obstetrician	2 (3.2)
Specialist Midwife	11 (17.7)
Mental Health Services	18 (29.0)
Mental Health Nurse	7 (11.3)
Perinatal Occupational Therapist	1 (1.6)
Psychiatrist	2 (3.2)
Psychologist	6 (9.7)
Talking Therapy Practitioner	2 (3.2)
Experience with Perinatal population	
Under 2 Years	9 (14.5)
2-5 Years	16 (25.8)
6-9 Years	15 (24.2)
10-13 Years	9 (14.5)
14-17 Years	6 (9.7)
18+ Years	7 (11.3)
Perinatal Mental Health Training	
Received no training	25 (40.3)
Received PMH training	32 (51.6)
Unknown	5 (8.1)

Identification of Perinatal Mental Health	
Used consultation conversation and non-verbal cues	28 (45.2)
Used validated scales/questionnaire as standard practice	15 (24.2)
Used validated scales/questionnaire if consultation highlights concerns	8 (12.9)
Unknown	11 (17.7)

Procedure

An original interview schedule was developed to address the research questions (for an outline, see Supplementary File 1). Semi-structured one-to-one interviews were conducted by one of two female postdoctoral qualitative research assistants (AD,RK) with training and experience of interviewing HCPs. Participants knew their interviewer was an academic researcher and were provided with the interview aims. Interviews were conducted by telephone or video call; the participant was at work or home. Brief field notes taken noting pertinent issues for clarification during the interview were not used in analysis. Interviews were audio-recorded on an encrypted device and transcribed verbatim by an authorised third-party. Transcripts were anonymised and checked for accuracy by the interviewer but not returned to participants.

Analysis

Data were analysed using framework analysis [33] a form of thematic analysis that uses a matrix to organize and interpret data within and between groups of HCPs in NVivo 14 [34]. An inductive-deductive coding approach was used to address specific research questions and allow identification of novel issues from the data. Following recommended practice for thematic analysis, the analysis proceeded through multiple stages [35]. The first stage involved familiarisation with the data, where one researcher (AD) read through the transcripts and relevant data was identified, generating codes identified using words and short phrases related to a meaningful organisation of the HCP's experiences, for example,

the verbatim quote *'you've got to be severe to get the quick support which could prevent then someone, if they got support early, it could prevent it escalating couldn't it?'* was given the code 'earlier treatment or support including interim care'. Further analysis involved re-consideration of all the codes to identify meaningful themes according to the analytic framework developed by the interviewers and agreed by the research team. For example, codes 'earlier treatment or support including interim care', 'continuity of carer or service', and 'HCP support and well-being', were combined into the category 'Optimisation'. The themes derived from the data using framework analysis by one author (AD) were checked by another author (UH) and the generated themes along with issues, re-considerations and additions to the framework were discussed within the research team at regular research meetings. In this way, themes were continually discussed and examined and new themes were considered from the data. Final themes were re-presented to, and endorsed by, the research study team. Transcripts and results were not returned to participants for feedback, but a summary was sent on request.

Results

Recruitment

Study information was sent to 121 HCPs; 81 gave consent, of which 18 were not contactable after initial interest. 63 Interviews occurred between February and July 2023. One participant withdrew their data after interview.

Sample Information

In the final sample (N = 62) average interview length was 44 minutes (range 21-68). The average age of participants was 40 years (range 24-61), with 6.5% (n = 4) of the sample identifying as male and 93.5% (n = 58) female. For reporting purposes, participants are labelled P1 to P62. Further sample information can be found in Table 1.

Framework Analysis

Results of the analysis are presented for each stage of the care pathway in themes relating to barriers, facilitators, and optimisation of care for perinatal anxiety. There is greater representation of universal HCPs in themes relating to identification, disclosure, referral and assessment and a greater representation of specialist HCPs in themes relating to care and treatment, reflecting their involvement in these stages. An overview of themes and mapping are presented in Table 2.

Table 2: Overview of Themes

Category	Stages of the pathway			
	Identification of Perinatal Anxiety	Disclosure of Perinatal Anxiety	Referral and Assessment for Perinatal Anxiety	Care and Treatment for Perinatal Anxiety
Barriers	Lack of understanding of perinatal anxiety Lack of mental health context in perinatal healthcare	Stigma of mental health Additional Vulnerabilities	Limited Understanding of the pathway Length and content of perinatal appointments Referral processes	Inaccessibility of appropriate care and treatments Long waiting lists for treatment Women not engaging with HCPs or services
Facilitators	Increased specialist support and use of tools for HCPs	Continuity of carer Flexibility in engagement	Self-referral Interprofessional working Referral systems	Multi-disciplinary collaboration Flexibility in treatment
Optimisation	Improving mental health education Collaborative Working	Early Intervention of mild/moderate perinatal anxiety	Enhanced interim care	Sustainable pathways for all

Identification of perinatal anxiety

Barriers to Identification

Lack of understanding of perinatal anxiety

Some HCPs working in universal services found it difficult to differentiate between women's worry and clinically significant symptoms of anxiety. This led to universal HCPs underplaying anxiety as 'normal' parenting worry.

'What you or I might feel is normal, somebody with anxiety will completely not and it will really freak them out. So, I think it's quite difficult for us to judge that sometimes as well, because you'll almost be like, I don't know what she's worrying about, but in her head she is really worrying about it.' (Hospital Midwife P51).

Lack of mental health context in perinatal healthcare

HCPs reported that universal perinatal healthcare was focused on physical health and/or infant well-being. Consequently, lack of assessment of mental health at each perinatal appointment created barriers to HCPs identifying, or women disclosing, a need for extra well-being support.

'I think the newborn check is very baby focused...I think mum does get relegated a little bit sometimes in those consultations, which, if somebody's coping okay is fine. But for those that are already struggling I think it can add to that'. (GP P5).

Facilitators to Identification*Increased specialist support and use of tools for HCPs*

HCPs working in universal services indicated that specialists (e.g., specialist PMH midwives and health visitors) supported them with: current information about care pathways and guidelines; support with difficult cases; decision-making; facilitating effective referrals.

'[The] Specialist Perinatal Mental Health Health Visitor is our lead in [our city] and then, she has good links with all the mental health services around, so, we can seek supervision with her, as well, if we're not quite sure.' (Health Visitor P36).

Likewise, tools and systems, such as a flowchart which enabled HCPs to assess pathway options quickly and accurately, were welcomed.

'The perinatal mental health pathway [produced for the local area]... is a lovely little visual reference point to look at...it's got embedded links for the referrals, so you just click on and refer...So we have that pathway, and we have kind of the green, amber and red pathway.' (Specialist Health Visitor P14).

Optimisation for Identification

Improving mental health education

HCPs working in specialist services reported receiving sufficient training for their roles. However, as reported in Table 1, 40.3% of all HCPs stated they had received no formal training in PMH. For universal perinatal HCPs that received PMH training this was reported as limited in duration and scope and insufficient for their roles. Participants indicated the need for improved PMH education for all involved with perinatal care: in core qualification; induction for new roles; and mandatory update training to maintain knowledge.

'People need a lot more training on... what is maternal mental health... it doesn't feel like there is any kind of like rolling with the times here. Like you are not keeping people up to date with what is going on.' (Health Visitor P33).

HCPs from both universal and specialist services reported that more training and education on medication use in pregnancy and lactation is necessary to ensure accurate advice is given to women for informed decision-making.

'Sometimes we see some drugs and we don't understand why... I mean I'm not that comfortable to speak about medication. I think we should have some training about that as well.' (Specialist Midwife P61).

Collaborative working

Effective communication between colleagues and services in universal perinatal healthcare supported the identification of women with perinatal anxiety via sharing of clinical insight regarding patients' needs.

'I think we are lucky that our midwife is based in our surgery. And that just makes lots of things easier discussions...we can speak about patients in difficulty, and I suppose I will just get advice from her. And that is really helpful.' (GP P3).

Disclosure of perinatal anxiety

Barriers to disclosure

Stigma of women's mental health

Participants found women may hold back from disclosing perinatal anxiety, or decline a mental health referral or diagnosis, due to concern about statutory services' involvement and fear their infant may be removed from their care.

'I think there is a barrier between other people...almost a distrust of health professionals sometimes. If you admit you've got a problem, social services are going to take your children away.' (Hospital Midwife P45).

Additional vulnerabilities for women

HCPs reported additional vulnerabilities created barriers to women engaging in meaningful discussion about their PMH. For example, financial or housing hardship may reduce women's focus on their mental health; women with physical or learning disabilities or those with neurodiversity can struggle to engage with care unless it is suitably adapted.

Women were less likely to disclose perinatal anxiety problems due to language barriers and cultural stigma of mental health, especially if accompanied to appointments by friends, family, or translators from the same culture, in the presence of whom open discussions about mental health may be held back.

'I was working with a lot of ethnic minority women and that presented its own challenges in terms of, you know, fear of engaging with services, and language barriers. It was a really complex population.' (GP P2).

Facilitators to Disclosure

Continuity of carer

Continuity of HCPs for universal perinatal care was thought to facilitate the identification of PMH distress through the development of trust and mutual understanding, allowing women to be candid about their mental health.

'I think the continuity is really good as well which I think really does benefit these women ...we're not seeing different people all the time, so it's quite predictable in the care that they're getting, and I think that really helps them.' (Specialist Midwife P52).

Flexibility in engagement

Across all healthcare settings, the ability to offer women flexibility in when and how appointments occurred was viewed as constructive: home visits; double appointments; drop-in clinics; adaptations to address language, culture, and vulnerability barriers; were reported as facilitating disclosure or identification of perinatal anxiety.

'Fifteen minutes with a woman, is not a long time... but I think the beauty of knowing your caseload is that you can actually say, well, I'll come and do a home visit and we can have a little bit more of a chat.' (Community Midwife P34).

Optimisation for Disclosure

Early intervention for mild/moderate perinatal anxiety

HCPs recognised that the perinatal period is a time of uncertainty with inherent anxiety, particularly after perinatal loss or trauma and for disadvantaged women. Professionals working in universal services were well-placed to address women's anxiety at an early stage. However, they highlighted the importance of having sufficient time: to discuss well-being; offer evidence-based reassurance and information on PMH issues; and to create opportunities for disclosure and signpost to support.

'They do a lot of, like, antenatal classes, regarding how to look after your baby...but I don't feel there's much awareness about mental health...so maybe integrate some of that into some of the classes maybe...when the women come antenatally, just using those opportunities to raise awareness about mental health.' (GP P62).

HCPs in different perinatal healthcare roles indicated benefits of offering more midwifery and health-visiting appointments earlier in pregnancy and postnatally. Ensuring all perinatal healthcare appointments include enquiries about both physical and emotional health and having continuity of HCPs was seen as aiding identification or disclosure of PMH problems, and women's acceptance of support when problems are identified.

'I think sometimes, eight weeks, if that's the last time you're seeing them, and then they're classed as universal [care] and they don't come to clinic, the next time you'll see them would be anywhere between nine to twelve months [postnatal]...So, I don't think we're having the opportunities to identify [perinatal anxiety], ...I think we do need another visit, potentially, at around four months.' (Health Visitor P21).

Referral and Assessment for Perinatal Anxiety

Barriers to Referral and Assessment

Limited understanding of perinatal anxiety care pathways

HCPs working in universal services found the complexity and changeability of mental health pathways made identifying options for gaining professional advice, signposting or referring women challenging, and was a barrier to making appropriate and successful referrals for women in their care.

'...not a lot of my colleagues are actually aware of these [specialist PMH] services, to be honest with you. Within our practice a lot of the GPs that I've asked, in our practice, have just kind of said, well the midwife will refer them on, or we would direct them to the local self-referral counselling service.' (GP P62).

Length and content of perinatal appointments

Lack of contact time and the substantial content of universal perinatal healthcare appointments made it difficult to explore mental health issues when they were identified, or to consider options and make suitable referrals.

'We're constantly clock watching, forty-five minutes to take somebody's entire medical history [at booking], their psychiatric history, their obstetric history, take their bloods,

do their clinical observations...because we've got so many targets and we're trying to do so many different things and tick so many different boxes, that you really have about two minutes to discuss mental health.' (Specialist Midwife P8).

Referral processes

Accessing the care pathway was seen as a potential barrier to engagement, for example where women did not understand why or where they had been referred, or the requirements to self-refer. Further, having to engage with several different HCPs for PMH assessment could be overwhelming.

'I think we often put the onus on the patient to do it [referral], because it means that they've got that drive to try and get some help for themselves. But I am aware that a lot of ladies don't follow it up.' (GP P17).

Facilitators to Referral and Assessment

Self-referral

HCPs suggested self-referral for mental health services for mild to moderate distress could facilitate engagement for some women but create barriers for others. Nevertheless, the ability to support women completing a self-referral to NHS or third-sector services enhanced engagement.

'If you refer somebody they might be less likely to opt in, but if you advise them to self-refer they might be likely to either not do it or underrepresent the problems, whereas if you support them to do it they are more likely to opt in.' (Talking Therapy Practitioner P50).

Interprofessional working

Clinical discussions between colleagues within teams and between universal maternity and specialist mental healthcare services was identified as facilitating decisions and effective referrals, supporting timely treatment and the efficient use of healthcare resources.

'Because of the integrated working, we're able to have like an anonymous chat with the staff, and they would say yes, signpost them to this... that... and they kind of

approve the referral before you've actually sent it in, just anonymously.' (Health Visitor P58).

Referral systems

HCPs in all roles reported large caseloads and associated time-pressures and appreciated processes and systems that enabled more efficient referrals. A centralised system, where a multidisciplinary team screened and allocated referrals to the appropriate MH pathway, was also welcomed.

'So, we now have some new pathways, where all the referrals go to one place and then they would vet the referrals and see which is the best part of their serviceit could be anyone that they do the referral to, but they do the vetting and the onward referral.' (Consultant Obstetrician P39).

Optimisation for Referral and Assessment

Enhanced interim care

It was considered advantageous for the referring HCP to have enough time and associated skills to offer more contact points as interim care and to monitor risk whilst a woman awaited specialist review for PMH.

'If I've done a second referral, then I will offer [to see] them in about two weeks' time to see how things have gone on from that consultation... I give them a follow-on appointment.' (GP P12).

Care and Treatment for perinatal anxiety

Barriers to Care and Treatment

Inaccessibility of appropriate care and treatments

HCPs also expressed that available treatment was not equivalent across the NHS, with different processes and treatment options.

'You'd be more likely to get [self-referral] links in certain geographical areas'(Commissioner P46).

HCPs also reported that access to specialist, multi-disciplinary perinatal MH services was often only obtainable by those with severe anxiety or in crisis, with a lack of care options for women with mild to moderate anxiety symptoms. Absence of treatments for women who are too unwell for talking therapy, but not unwell enough to be accepted by specialist PMH services, was also reported.

'There is a huge gap...some women that wouldn't fit with secondary services, and then perhaps, IAPT [Improving Access to Psychological Therapies] is not enough...where you've got someone who doesn't fit a category, what do you signpost?' (PMH Nurse P56).

Long waiting lists for treatment

When referrals were accepted by MH services, long waiting times were common before treatment. Referring HCPs reported frustration about lack of support for women on waiting lists and were concerned about lack of monitoring for changes to severity of distress.

'Pregnancies are short and if you've got three- or four-month waiting list and you're referring somebody at thirty-five, thirty-six weeks pregnant, they'll not be seen in their pregnancy. So, it's just being able to have additional staff that are able to see people timely and support them through a massive event in their life.' (Hospital Midwife P40).

Women not engaging with HCPs or services

HCPs reported that some women did not accept the treatment offered. For example, prior negative experience of therapy meant some women did not feel treatment would be worthwhile; there was also reluctance to take medication in pregnancy or during lactation. Further, demands of the perinatal period or life circumstances were reported as making it harder for women to attend appointments or participate in treatment.

'So, if there are other psychosocial stresses going on, there are other co-morbidities as well...they may regularly not attend outpatient appointments. And then it's really difficult to work with these women because we can't keep offering them appointments - they will, eventually, get discharged from our service.' (Consultant Psychiatrist P29).

Facilitators to Care and Treatment

Multi-disciplinary collaboration

Mental health HCPs reported that multi-disciplinary collaboration enabled women to benefit from more individualised treatment and effective transitions between different HCPs.

'We've got really good connections actually...their [team of different HCPs] attitude to it all is just fantastic, just really passionate, and really just wanting to make sure that our ladies get the best care... we invite in different professionals from different teams...it means that we can say, look, we've referred someone over to IAPT, have you picked that up? How's it going?' (Perinatal Occupational Therapist P 28).

Flexibility in treatment

Flexibility and choice regarding how, when and by whom treatment was delivered was reported as pertinent to women's engagement.

'The best thing about our service...and does make a difference, is the ability to meet the patients in a very slow way. So, I've got no DNA [did not attend] rates with my ladies...you negotiate how you want to see them...so that I usually see them online first, and eventually we end up on a ward, if they'd had a delivery that hasn't gone well. And we end up doing the exposure work [for fear of birth] in a very gentle way, naturally.' (Clinical Psychologist P60).

Optimisation for Care and Treatment

Sustainable PMH pathway for all

HCPs considered that, beyond specialist mental health services, perinatal anxiety pathways need to incorporate a structured approach to self-help, peer support, and third sector support. Further, the pathway needs to meet the needs of all parents not just the birthing person, ensuring all levels of distress from mild to severe are included, with provision for multi-disciplinary care to address individual needs.

'What I would like is something that's kind of in between the GP and perinatal services, that's like, just available, for those clients, who, we might not have time to sit with...like an anxiety specific maternity service, that could be for those kind of low grade [women].' (Community Midwife P44).

There was a view that pathways should be adequately resourced to ensure availability of treatments is sustainable, waiting-times limited, continuity afforded to women, with flexibility in the provision of treatment and support to account for the nature of the perinatal period and population diversity.

'I think the main thing is just to have more availability. I think there's so much pressure on everybody on a day-to-day basis that I think the luxury would be just to have more people to go round, so therefore you've got more time to spend with women and not so much under the pressure of needing to move people through.' (Service Manager P41).

Support and supervision for HCPs

HCPs reported having full and often complex caseloads that could affect personal well-being, professional manner, and lead to high rates of absence and turnover. Therefore, providing enhanced support and supervision for HCPs could assist personal health and enable provision of higher quality, reliable care for women.

'Senior colleagues who are dealing with really heavy conversations daily really need that supervision. And, in turn it will improve practice and it would probably improve staff anxiety.' (Specialist Midwife P9).

Discussion

This is the first study of perinatal anxiety to explore the perspectives of HCPs working in universal and specialist perinatal healthcare services across the UK. Barriers and facilitators were reported relating to identification and disclosure, referral and assessment, and care and treatment for perinatal anxiety. Our research found similar barriers to support and treatment for perinatal anxiety as exist for women with other common mental health problems during the perinatal period [9]. There were also proposals for optimisation of all stages of care pathways. Important differences were noted between the experiences of HCPs working in universal and specialist services. HCPs in universal services were mostly involved in the identification, referral and assessment stages of care pathways and many of them expressed concerns regarding a general lack of understanding of perinatal anxiety and the complex pathways and referral systems involved. HCPs working in specialist services were satisfied with their knowledge and training but expressed concerns with the pressures of earlier stages of the care pathways and limitations such as time constraints, which affected their ability to care and treat women with perinatal anxiety. These results are discussed in comparison with previous literature and regarding their practical implications for training and workforce and other forms of support.

Training and workforce

HCPs working in universal services identified barriers relating to lack of training and understanding of perinatal anxiety and PMH, for example regarding thresholds for clinical concern and up-to-date awareness regarding complex circumstances. Previous research has identified this issue of HCPs being unfamiliar with perinatal anxiety [8], and this is also consistent with views expressed by UK public health nurses and midwives [11,13]. Lack of confidence in training compromises effective early decision-making involving pre-conception, pregnancy and postnatal care. For example, GPs and midwives may be involved with discussions with women about the use and/or cessation of medications during pregnancy

and lactation yet lack sufficient up-to-date knowledge about psychotropic medication [28]. Ensuring adequate training and education for PMH and perinatal anxiety for HCPs working in universal services is important. Regularly updated training regarding screening tools and referral thresholds could improve identification and assessment, which in turn could relieve pressure on specialist services involved with PMH care and treatment. Furthermore, this could incorporate guidance on the use of specialist PMH toolkits. For example, the Royal College of General Practitioners (RCGP) in collaboration with the Maternal Mental Health Alliance, developed open resources for HCPs working with PMH and the use of GP champions to cascade training via existing local networks was successfully trialled [36]. This could be usefully expanded given sufficient resources. However, the availability of resources and time limits opportunities for training and collaboration between HCPs in multidisciplinary teams. Inter-professional working is an opportunity to increase support for HCPs and also relieve pressure on the system. In the present study, challenges due to the complexity of mental health pathways for HCPs in universal services were mediated where there were opportunities for working collaboratively with specialist HCPs, sharing expertise and facilitating effective decision-making and referrals, as reported in other studies [37]. Regardless of the effectiveness of professionals and resources, HCPs in universal and specialist services report that some women are reluctant to disclose or accept treatment for their perinatal anxiety. UK clinical guidelines currently recommend HCPs ask women about their mental health at each routine perinatal appointment [38], with guidelines for the use of screening questions and validated scales at antenatal booking and the 6–8-week postnatal appointments [19]. Since 2020, GPs have been contracted to complete a specific maternal postnatal consultation, including enquiries about mental health [39]. However, stigma surrounding mental health acts as a barrier to disclosure and may be exacerbated by distrust of unfamiliar carers, previous mental health problems, cultural factors and additional vulnerabilities, such as financial hardship [40]. Therefore, although training and enhanced understanding of mental health would be helpful, there also needs to be change in health services. For example, pathways that facilitate continuity of care and have a more

individualised approach for all would allow HCPs to develop trusted relationships within which women can disclose their symptoms [9].

Furthermore, our research identified that there remains a lack of clarity about provision for mild and moderate perinatal anxiety. There are many reasons why referrals for mild and moderate anxiety may not happen. Women themselves may be reluctant to accept a mental health referral, for example due to concerns about stigma, long waiting times, previous healthcare experiences or a lack of confidence in available treatment options. Equally, HCPs in universal services may feel able to manage mild distress without referrals. However, HCPs in the present study stated the importance of addressing the range of severity, from mild to severe symptoms, with interventions from low level self-help through to intensive specialist treatments, albeit with the need for additional. NHS England [22] outline the PMH pathway in terms of assessment and treatment for complex and severe mental health difficulties. Developing clear pathways for mild and moderate PMH represents an opportunity to support women with early interventions and before it becomes more serious and increasingly costly to address [17]. Research specifically focussing on reasons for non-referral may help to increase the effectiveness of interventions.

Community Level Support

In this study, HCPs raised that there are limitations which affect the ability to provide effective care; also reported previously [11,12]. Specialist HCPs reported restricted time for consultations and the availability of mental health services for referral. Further, HCPs from universal services reported limited resources to offer women whilst they were waiting for review and treatment, which involved long waiting times in some areas and limited options for women who were too unwell for talking therapies but not severe enough for urgent referral. This involves risk as there appears to be little opportunity for monitoring women and processes during this interval; often a reliance on the woman herself flagging decline in her own PMH. This is problematic since women with mental health problems may not be in a position to self-refer, and inequalities and cultural factors will exacerbate referral reluctance.

This study supports the view that longer term strategic service planning will require additional funding in order to provide the numbers and balance of HCPs to deliver an improved service, particularly for women waiting for services and those with mild and moderate distress [13,16]. An expansion of universal services could be particularly efficient. Despite increased investment in specialist PMH services, there has been a reduction in some universal services, such as health visitors [21]. Resources are not infinite, however additional resources focussed on universal services, such as increased training and recruitment of health visitors, and an expansion of local services such as family hubs, would provide support and opportunities for early intervention.

Strengths and limitations

The current study provided a comprehensive investigation of current UK care for perinatal anxiety and how it can be optimised within health services. Findings are strengthened by: the large sample of HCPs; wide range of disciplines; representation from primary, secondary, and tertiary settings across the UK; and from England and Scotland. Interviews from HCPs in both universal and specialist services provided enhanced understanding of the differences in the perspectives of these professionals.

Participants were self-selecting; the sample may be skewed to include those with interest or expertise in PMH; and was also predominantly female; therefore, not necessarily reflective of all universal HCPs. All participating HCPs provided their experiences and views on PMH care in the NHS in England and Scotland, therefore, findings may not be applicable to other healthcare systems or countries.

The availability of PMH healthcare is based on localised commissioning and staffing, which was not equivalent across the regions sampled. Further research to investigate the impact of geographical differences, such as a comparative review of regional differences in PMH provision, is important to ensure consistent care and treatment.

Conclusions

Despite significant investment in PMH in the UK, HCPs in the current study acknowledged barriers to their ability to care for women with perinatal anxiety at all stages of care pathways. Successful identification of perinatal anxiety would be increased if: mental health were included in all universal appointments, as recommended by NICE [38]; there was greater mental health education and training for HCPs, especially those in universal services; and greater collaborative working to improve communication and support for parents and HCPs. Longer term strategic service planning will require additional funding in order to provide the numbers and balance of HCPs to deliver an improved service, particularly for women with mild and moderate distress and to address waiting times and geographical inequalities.

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Author contributions

The study was conceptualised and designed by SA, RM, HC, MM, AS, PM. Project documentation and ethical approvals were completed by PM. Recruitment of PICs and CRNs was led by PM and supported by AD. The interview schedule was original, developed for this study by PM and available in Supplementary File 1. Recruitment and consent of participants was carried out by AD and research interviews conducted by AD and RK. AD conducted coding and analysis of the data. Analysis was checked in an exercise of trustworthiness by UH and developed through feedback from UH, RM and PM. The first full version of the paper was completed by AD with guidance from UH, RM, PM and SA and all authors reviewed the final manuscript.

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Data availability

Individual participant level information is not available to preserve anonymity but research material, analytic codes and sample level information is available from the corresponding author on reasonable request.

Declaration**Ethics approval and consent to participate**

Ethical approval was gained from the School of Health Sciences Research Ethics Committee at City, University of London. The project had HRA approval (22/HRA/4584) and the study adhered to all guidelines of the Declaration of Helsinki. Informed consent was obtained for all participants prior to interview.

Consent for publication

Not applicable

Competing interests

The authors declare no competing interests.

Abbreviations

CRN Clinical Research Network (now replaced by Research Delivery Network (RDN))

HCP Healthcare Professional

IAPT Improving Access to Psychological Therapies (now NHS Talking Therapies)

MH Mental health

NHS National Health Service

NICE National Institute for Health and Care Excellence

PIC Participant Information Centre

PMH Perinatal Mental Health

UK United Kingdom

References

1. O' Hara MW and Wisner KL. Perinatal mental illness: Definition, description and aetiology. *Best Pract Res Clin Obst Gynaecol.* 2014; 28(1), 3-12; doi: 10.1016/j.bpobgyn.2013.9.002.
2. Ayers S, Sinesi A, Coates R, Cheyne H, Maxwell M, Best C, McNichol S, Williams LR, Uddin N, Shakespeare J, Alderdice F, Map Study team. When is the best time to screen for perinatal anxiety? A longitudinal cohort study. *Journal of Anxiety Disorders.* 2024; doi:10.1016/j.janxdis.2024.102841.
3. Bayrampour H, Vinturache A, Hetherington E, Lorenzetti DL, & Tough S. (2018). Risk factors for antenatal anxiety: A systematic review of the literature. *Journal of Reproductive and Infant Psychology*, 36(5), 476–503; doi:10.1080/02646838.2018.1492097
4. Coelho HF, Murray L, Royal-Lawson M, Cooper PJ. Antenatal anxiety disorder as a predictor of postnatal depression: a longitudinal study. *J Affect Disord.* 2011; 129:348-53; doi: 10.1016/j.jad.2010.08.002
5. Ding XX, Wu YL, Xu SJ, Zhu RP, Jia XM, Zhang SF, et al. Maternal anxiety during pregnancy and adverse birth outcomes: a systematic review and meta-analysis of prospective cohort studies. *J Affect Disord.* 2014; 159:103-10; doi: 10.1016/j.jad.2014.02.027
6. Rees S, Channon S, Waters CS. The impact of maternal prenatal and postnatal anxiety on children's emotional problems: a systematic review. *Eur Child Adolesc Psychiatry.* 2019; 28:257-80; doi: 10.1017/s00778-018-1173-5

7. Ford E, Shakespeare J, Elias F, Ayers S. Recognition and management of perinatal depression and anxiety by general practitioners: A systematic review. *Family Practice*, 2017; 34 (1): 11-19; doi:10.1093/fampra/cmw101.
8. Silverwood VA, Bullock L, Turner K, Chew-Graham CA, Kingstone T. The approach to managing perinatal anxiety: a mini-review. *Front Psychiatry*. 2022; doi: 10.3389/fpsyt.2022.1022459
9. Webb R, Uddin N, Ford E, Easter A, Shakespeare J, Roberts N, Alderdice F, Coates, R, Hogg S, Cheyne H, Ayers S, MATRix Study Team. Barriers and facilitators to implementing perinatal mental health care in health and social care settings: a systematic review. *Lancet Psychiatry*, 2021 Jun;8,6,521-534; doi:10.1016/S2215-0366(20)30467-3
10. Smith MS, Lawrence V, Sadler E, Easter A. Barriers to accessing mental health services for women with perinatal mental illness: systematic review and meta-synthesis of qualitative studies in the UK. *BMJ Open*. 2019; doi:10.1136/bmjopen-2018-024803.
11. Ashford MT, Ayers S, Olander EK. Supporting women with postpartum anxiety: exploring views and experiences of specialist community public health nurses in the UK. *Health Soc Care Community*. 2017; doi: 10.1111/hsc.12428.
12. Ford E, Lee S, Shakespeare J, Ayers S. Diagnosis and management of perinatal depression and anxiety in general practice: a meta-synthesis of qualitative studies. *Br J Gen Pract.*, 2017; doi:10.3399/bjgp17X691889.
13. Royal College of Midwives. Strengthening Perinatal Mental Health: a Roadmap to the Right Support at the Right Time. 2023. <https://www.rcm.org.uk/media/6976/rcm-perinatal-mental-health-report-2023.pdf>. Accessed 24 Oct 2023.
14. Borglin G, Hentzel J, Bohman DM. Public health care nurses' views of mothers' mental health in paediatric healthcare services: a qualitative study. *Prim Health Care Res Dev*. 2015; doi:10.1017/S1463423615000055.

15. Higgins A, Downes C, Carroll M, Gill A, Monahan M. There is more to perinatal mental health care than depression: public health nurses reported engagement and competence in perinatal mental health care. *J Clin Nurs*. 2018; doi: 10.1111/jocn.13986.
16. Lowenhoff C, Appleton JV, Davison-Fischer J, Pike N. NICE guideline for antenatal and postnatal mental health: the health visitor role. *J Health Visit*. 2017; doi:10.12968/johv.2017.5.6.290
17. Bauer A, Parsonage M, Knapp M, Lemmi V, Adelaju B. The Costs of Perinatal Mental Health Problems. Centre for Mental Health and London School of Economics. 2014. <https://centreformentalhealth.org.uk/wp-content/uploads/2018/09/costsofperinatal.pdf>
18. NHS. The NHS Long Term Plan. 2019. <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf>. Accessed 24 Oct 2023.
19. NHS England. Five Year Forward View. 2014. <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>. Accessed 24 Oct 2023.
20. NHS Mental Health Implementation Plan 2019/20-2023/24. <https://www.longtermplan.nhs-mental-health-implementation-plan-2019-20-2023-24>. Accessed 24 October 2023.
- 21.** Institute of Health Visiting (IHV). Health visitor survey finds that more babies and young children are missing out on the government's promise of 'the best start in life'. 18th January, 2023. <https://ihv.org.uk/news-and-views/news/health-visitor-survey-finds-that-more-babies-and-young-children-are-missing-out-on-the-governments-promise-of-the-best-start-in-life> Accessed 14 June 2024.
22. NHS England. The Perinatal Mental Health Care Pathways. 2018. <https://www.england.nhs.uk/publication/the-perinatal-mental-health-care-pathways/>. Accessed 24 Oct 2023.
23. NHS Scotland. Scottish Perinatal Mental Health Care Pathways. National Managed Clinical Network. 2021. <https://www.pmhn.scot.nhs.uk/care-pathways/>. Accessed 24 Oct 2023.

24. Maternal Mental Health Alliance. A Sound Investment: Increasing Access to Treatment for Women with Common Maternal Mental Health Problems. 2022. <https://maternalmentalhealthalliance.org/wp-content/uploads/a-sound-investment-report-centre-for-mental-health-2022-mmha.pdf>. Accessed 24 Oct 2023.
25. Noonan M, Doody O, Jomeen J, Galvin R. Midwives' perceptions and experiences of caring for women who experience perinatal mental health problems: an integrative review. *Midwifery*. 2017; doi:10.1016/j.midw.2016.12.010.
26. Viveiros CJ, Darling EK. Perceptions of barriers to accessing perinatal mental health care in midwifery: a scoping review. *Midwifery*. 2019; doi:10.1016/j.midw.2018.11.011.
27. Long MM, Cramer RJ, Jenkins J, Bennington L, Paulson JF. A systematic review of interventions for healthcare professionals to improve screening and referral for perinatal mood and anxiety disorders. *Arch Women's Ment Health*. 2019; doi: 10.1007/s00737-018-0876-4.
28. Bayrampour H, Hapsari AP, Pavlovic J. Barriers to addressing perinatal mental health issues in midwifery settings. *Midwifery*. 2018; doi: 10.1016/j.midw.2017.12.020
29. Frayne, J., Seddon, S., Lebedevs, T. *et al.* General practitioner perceptions and experiences of managing perinatal mental health: a scoping review. *BMC Pregnancy Childbirth* **23**, 832. 2023. doi:10.1186/s12884-023-06156-6
30. Silverwood V, Nash A, Chew-Graham CA, Walsh-House J, Sumathipala A, Bartlam B, Kingstone T. Healthcare professionals' perspectives on identifying and managing perinatal anxiety: a qualitative study. *Br J Gen Pract*. 2019; doi:10.3399/bjgp19X706025.
31. Research Registry. Optimising care for perinatal anxiety: evaluation of health service utilisation, outcomes and costs (MAP ALLIANCE). researchregistry7767. 2022. <https://www.researchregistry.com/browse-the-registry#home/registrationdetails/624463b527c6870021163fb9/>.

32. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *Int J Quality Health Care*. 2007;doi:10.1093/intqhc/mzm042.
33. Ritchie J, Lewis J, Ormston R, Nicholls CM, editors. *Qualitative research practice: a guide for social science students and researchers*. Sage Publications. 2013.29.
34. Lumivero. NVivo (Version 14). 2023.<https://www.lumivero.com>.
35. Braun V & Clarke V. Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*; 11 (4); 2019; doi: 10.1080/215967x.2019.1628806
36. NHS South East. The Spotlight Pilot Project.
2020<https://www.southeastclinicalnetworks.nhs.uk/the-spotlight-project/>
37. Moran PM, Coates R, Ayers S, Olander EK, Bateson KJ. Exploring interprofessional collaboration during the implementation of a parent-infant mental health service: A qualitative study. *Journal of Interprofessional Care*, 37,6, 877-885, 2023.
38. NICE. Antenatal and Postnatal Mental Health. NICE (National Institute for Health and Care Excellence) Quality Standard. 2016.
<https://www.nice.org.uk/guidance/qs115/resources/antenatal-and-postnatal-mental-health-pdf-75545299789765>. Accessed 26 October 2023.
39. NHS England. GPs six to eight week maternal postnatal consultation – what good looks like guidance. 2023.<https://www.england.nhs.uk/long-read/gp-six-to-eight-week-maternal-what-good-looks-like-guidance/>. Accessed 31 Jan 2024.
40. Edge, D. Falling through the net – black and minority ethnic women and perinatal mental healthcare: health professionals' views. *Gen Hosp Psychiatry* 2010; doi: 10.1016/genhosppsy.2009.07.007.

ⁱ It is recognised that there are standardized NHS pathways but HCPs may also report their experience of localised pathways that may differ according to local commissioning and staffing