



Barriers to accessing mental health services for postnatal depression in the UK: a literature review

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NB: These findings should not be cited without the author's permission as this could jeopardise publication in peer refereed scientific journals.

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Introduction

Postnatal depression (PND) is believed to affect 10-15% of mothers in the early months after birth (Cooper et al., 1988; O'Hara & Swain, 1996, Leverton & Elliott, 2000). It has a negative effect on the quality of life for these women, is also associated with high levels of depression in fathers (Ballard, 1996) and impacts on the cognitive and social development of children (Cooper & Murray, 1995; Murray & Cooper, 1997; Martins & Gaffan, 2000).

Many of those affected by PND may not be receiving appropriate care: the NHS Direct webpage reports: "A study carried out into postnatal depression showed that only 1 in 4 women sought any help" (NHS Direct Online Health Encyclopaedia). This review aims to provide a critical interpretive synthesis (CIS) of the evidence concerning barriers to access to mental health services for PND in the UK. The research data on this topic are varied and include evaluations of interventions, quantitative surveys that tap the views of patients and health professionals, and qualitative interviews accessing the experiences of women with PND and of health professionals. Methods for reviewing and synthesising such diverse forms of evidence have been the topic for much recent debate. CIS has been demonstrated to provide a useful framework that draws upon qualitative methodology to analyse diverse evidence, generate categories and consider the links between them in order to develop new explanatory theory (Dixon-Woods et al. 2006).

CIS does not exclude papers on the basis of any hierarchy of evidence or quality checklist. Dixon-Woods et al., (2006) argue that this is not desirable for several reasons: there is no 'hierarchy of evidence' for qualitative data and no consensus on how to appraise papers for inclusion in reviews; quality check lists can exclude papers that may make a substantial theoretical contribution on the basis of 'surface mistakes' (Dixon-Woods et al., in press; Sandelowski, 1997). Instead, CIS is inclusive in order to ensure that any papers that may make valuable contributions are not excluded and involves criticism, at all stages of analysis and synthesis, throughout the process. This requires a recursive and reflexive approach.

This review focuses on UK evidence because it aims to inform policy making and practice within a NHS, UK context. Whilst research in other countries may inform theories concerning what influences women's access to mental health services for PND, there are likely to be differences arising from the variations in service delivery and cultural and social contexts between countries. It is therefore considered preferable to review each country independently before attempting to achieve a broader synthesis.

Search strategy:

The searches were designed to elicit all relevant published research on PND, and generate a list of abstracts to be screened for relevance to the specific topic of the review. The databases searched are listed in table 1. All searches were conducted in March 2006. Search terms included postnatal depression, postpartum depression, depressive disorders; depression. SureStart was also included as a search term in order to ensure that any articles specifically relating to PND in the context of the SureStart policy would be included. A full account of search terms by database is given in appendix 1.

Table 1. Databases searched.

Database	Date Searched	Year Range
PsycInfo (Dialog)	14.3.06	1980-
PsycArticles (ebSCO)	29.3.06	1980-
Medline (Ovid)	13.3.06	1966-
Embase (Ovid)	22.3.06	1980-
ASSIA (CSA)	20.3.03	1987-
Science Citation Index / (Web of Knowledge)	27.3.06	1980-
Social Science Citation index/ (Web of Knowledge)	27.3.06	1980-
Sociological Abstracts CSA	29.3.06	1980-
Kings Fund (subset HMIC (Dialog)	15.3.06	1980-
DH – DATA (subset HMIC) (Dialog)	15.3.06	1980-
Cinahl (Dialog)	22.3.06	1980-
Social Services Abstracts CSA	29.3.06	1979
Medline in-process	29.3.06	new

Method

Two of the authors, Elizabeth Ockleford and Sheila Bonas (EO and SB), screened the abstracts generated by the searches. Any contentious cases were left in, in order to make the review as inclusive as possible.

After initial screening of abstracts for duplications, relevance and country on which the work was based the full papers were read and any relevant data extracted. The data extraction procedure was conducted by EO and SB using a proforma. The main aims of the study, research methods used, main findings, potential analytical categories and general comments were all recorded. Each author checked a sample of the other's data extraction notes to assess rigour and consistency of approach. The method of analysis used constant comparison (Glaser & Strauss, 1967). During data extraction, theoretical memos were recorded to capture information on the interpretation process and to develop theories concerning relationships between constructs. The themes arising from this first phase of analysis are described in the section below. EO and SB reviewed the themes and discussed relationships between them in order to achieve further synthesis of the data. The 'critical' aspect of the CIS method was addressed by

questioning the assumptions underlying the research reported in the literature, the methods used and the conclusions drawn. We aimed to discover key categories which represent the research findings in order to develop theory to explain the current situation and to inform future practice and policy development.

Findings

The total number of articles retrieved by searches was 464. After screening for UK papers, 228 remained, and after screening abstracts for relevance there were 74. The full papers of these 74 articles were then further checked for relevance and 40 papers went forward for data extraction. During the final interpretive analysis of themes, further papers were excluded if they did not make a useful contribution, leaving 26 papers contributing to the final review. These are listed in the data extraction table in Appendix 2.

Figure 1. Themes from research papers

Accessing mental health services for PND		
Women's perceptions of PND	Interactions between women and service providers	Health service provision
Stigma		
Being a 'bad mother'	Trust	Identifying PND
Fear of consequences of labelling	Communication	Roles of health professionals
Acceptability of treatment	Mismatch between what women want and what is provided	Continuity of care
Poor perceptions of service provision		Referrals
Need for more knowledge		
Mothers' perceptions of causes of PND		Training
Ethnic / class / cultural issues		

Themes from research papers:

The themes emerging from the papers have been organised into three groups: women's perceptions of PND, health service provision and interactions between women and service providers. Several sub-categories are described under each group (See Figure 1). The relationships between some of the themes are developed further in the discussion.

Women's perceptions of PND

Many of the papers discuss how the knowledge and perceptions of women can act as a barrier to accessing mental health services for PND.

Stigma

The stigma associated with mental illness is well reported in the literature and also appears in the research specific to PND. The stigma of a PND diagnosis can act as a barrier to accessing health services, or even disclosing their difficulties to close family members, by motivating women to draw a veil of secrecy around their condition. For example:

“When I was on the mother and baby unit I was really paranoid about what people would think. ... I was worried what people would think, that I wasn't coping with having a baby... I just didn't want people to know I had a mental illness ...” (Edwards & Timmons, 2005. p.475.)

“I didn't like to tell my mum. You don't want people to think you're falling apart and can't cope.” (McIntosh, 1993. p.181.)

The stigma may be associated with a fear of social services involvement and child protection if a mother is identified as suffering from mental illness. On the basis of interviews with health visitors, this was identified as a reason why this group of professionals were not approached by their clients about PND:

“There was a variety of reasons why health visitors were not the first healthcare professional to be approached by the client. These included the potential stigma perceived by the client of health visitors' involvement in child protection and their subsequent collaboration with social services.” (Brown & Bacigalupo, 2006. p.50.)

Being a 'bad mother'

The moral dimension to stigma is often associated with a fear of being seen as a 'bad mother' or a failure which can prevent women from disclosing their worries to health professionals (see also examples under the 'Identifying PND' theme below):

“I was actually scared to hold him and I hated that, because I had this vision of, picture of how I would be as a mother and I didn’t live up to that expectation, so it made me feel quite bad ...” (Edwards & Timmons, 2005. p.477.)

“I felt like I was a bad mother. I couldn’t cope with it all ... I still feel that I’m a failure ‘cos I couldn’t do it ... I sort of gave into this, if you like, it got hold of me and I was weak” (Mauthner, 1997. p.168.)

“Many women deny they are depressed or suffer alone in shame or guilt. Many are aware that they are not their usual selves, but are reluctant to tell others because they fear they will be thought a ‘bad mother’ or that they are ‘going mad’.” (Foyster, 1995. p.151.)

Labelling

A theme that is closely linked to stigma and being a bad mother is that of labelling. Several authors report a fear of being labelled as ‘mentally ill’ or a ‘bad mother’ and fear of the consequences of such labelling if it leads to being considered an ‘unfit mother’ and children being removed into care. Consequently, the role of health visitors in ensuring safety of the child may be a barrier to women disclosing their problems:

“When you mention to the baby ladies that you’re depressed, they’re frightened for the baby, not for you in case in your depression you hit the baby. So if they find out you’re depressed, they take the baby away for safety.” (McIntosh, 1993. p.182.)

The counter side to having a label applied at diagnosis of PND can be relief at knowing that many others have the same problem or at having the difficulties experienced ‘legitimised’, enabling women to accept treatment:

“Mothers have said repeatedly how alone they felt, and how relieved they were to find others feeling the same.” (Pitts, 1995. p.145.)

“...six of the eight non recovered counselled women had consulted their doctor and had taken antidepressants, compared with only two of the non-recovered controls....The intervention had presumably ‘legitimised’ their depression.” (Holden 1996. p.82.)

Acceptability of treatments

Several authors discuss the problem of women being reluctant to accept a diagnosis and orthodox treatments because of the stigma associated with them, or concerns about dependency or side-effects of anti-depressants.

“I went to the doctors to get a wee [little] tonic. He tried to give me valium. I says, ‘Away you go, once you go on them you can’t get off.’ He says, ‘They’re not addictive’. I says, ‘Aye they are.’ I wouldn’t have them.” (McIntosh, 1993. p.182-3)

“The doctor put me on anti-depression tablets but I don’t take them. I only took one. I couldn’t keep my eyes open. I think they’re terrible tablets to give someone with a new baby ... The doctor thinks I’m still takin’ them. I pretend. It keeps him happy.” (McIntosh, 1993. p.182.)

In their sample of women with PND Whitton et al. (1996) found 81% said they would not consider pharmacological treatment. Of these, around half thought they would recover without drug treatment and about one in 5 were concerned about addiction. In contrast, when asked about acceptance of psychological treatment, a majority (60%) were willing to consider this. The use of complementary and alternative therapies (CAMs) including Ayurvedic medicine, herbalism, homeopathy, aromatherapy, hypnosis and traditional Chinese Medicine is considered by Mantle (2001). She points to patients’ rights to access CAMs. However, even if CAMs carry less stigma, the evidence base of evaluations of the efficacy of these therapies is poor and their use diverts resources from tested, conventional approaches.

Poor perceptions of service provision

In a multi-centre study with 7 clinics in different European centres including London, Chisholm et al. (2004) identified the following ‘commonly expressed constraints’ to accessing service:

“perceived lack of quality or responsiveness of health care providers to their needs; a concern about medication side-effects, should anti-depressant pharmacotherapy be prescribed; and other reasons, in particular, lack of time or inability to find a child minder.” (Chisholm et al. 2004. p.49.)

All of the reasons listed were offered from the London participants. Further examples of fears relating to pharmacotherapy have been given in the theme of ‘acceptability of treatments’. Other negative accounts are given with regard to treatment (see acceptability of treatment theme), and to the lack of ‘fit’ between what women think the problem is and what is on offer. This is explored further in the next theme and in the ‘mismatch’ theme.

Misperceptions and misgivings about the services offered are exemplified by:

“I thought I’d be put in a room with other teenage mums and it would be like someone telling us what to do and that kind of thing...”

(Tiffany)

“I think in my head I thought it was going to be a weekly visit of somebody asking me a load of questions, not actually giving me support.” (Vanessa)

“I wasn’t really sure what ‘support’ meant, because all I really needed was a hand, physically, with stuff... I asked whether some of the support would be practical, like, would I be allowed to go and have a nap, or would I be allowed to sit down, and they explained... (the interviewer) said it would be someone talking to you - and I needed that like a hole in the head!” (Sandra) (Barlow et al., 2005. p.204.)

Need for more knowledge

There is evidence that women fail to respond to their symptoms and access help because they are poorly informed about PND. Whitton et al. (1996) found that 80% of the women suffering PND in their study had not reported their symptoms to any health professional. While over 90% recognised that something was wrong, only one-third thought they were suffering from PND. Knowledge of the gradual onset was seen as important, so women could avoid the slide into PND (Holden, 1996). Whitton et al. (1996) reinforce this, saying that women need to be more able to recognise the symptoms and propose antenatal education to address this. This problem was highlighted by patients interviewed for Mauthner’s study:

“They covered the baby blues... but there was no mention of ‘It could take a few weeks or months before you start to be Jekyll and Hyde’ ... and there was nothing like ‘If you’re having trouble come back and see us’ ... I think they should really cover it a lot more and they should let some of these poor women know what they could possibly face, and if it did happen to them that there was people who could help.” (Mauthner, 1997. p.166.)

“I think it can be mentioned by people at antenatal clinic without worrying it’s going to become a big problem ... It’d be nice to know, if you felt like that afterwards, that it struck a chord, and you’d think, ‘Ah, it’s not strange to think like this. I’m not failing as a mother ... The midwife did say this could happen’ - and then you’d probably feel happier and more confident to go to the doctor and say ‘I’m experiencing this.’ (Mauthner, 1997. p.166.)

Mothers' perceptions of causes of PND

McIntosh (1993) reported that many of the participants in his study attributed their depression to multiple causes. The most commonly cited were 'aspects of motherhood':

"I'm depressed because it's boring, lonely and the work's never-ending. I'm used to working and all of a sudden you're stuck in the house all of the time. Sometimes you get to the stage you go out and grab the first person you see..." (McIntosh, 1993. p.180.)

Other reasons given are social, such as housing or financial problems and some blamed 'hormones'. McIntosh argues that as these women see their depression as a 'normal' response to 'abnormal' circumstances, they do not consider themselves to be ill. These women seem to be seeking more practical help rather than drug therapy or psychological therapy or support. Consequently, there was no reason to seek professional assistance:

"What could the doctor do? He can't sort out my man or any of my other problems. They only give you pills."

"What's the point of speaking to them [health visitors]. Are they going to take the baby off my hands and give me a break? No. A waste of time." (McIntosh, 1993. p.182)

Ethnic, social or cultural differences

Different groups can have varying views on mental illness, child care and support. Perceptions of stigma, were exemplified by the quotation "don't hang your dirty laundry out" and an imperative to be a good mother and take care of one's child are found in most groups. These views can be exacerbated by acculturation or other cultural phenomena (Templeton et al., 2003). Greek fathers were found by Thorpe et al. (1992) to be more emotionally and physically distanced from their partners than were British fathers, but these differences did not result in lower emotional well-being of the mothers, as measured by the Edinburgh Postnatal Depression Scale (EPDS). They speculate that this may be because of differences in social expectations between the two cultures. This paper is now 16 years old and treating a population of parents recruited via British clinics in Bristol as a 'mono-culture' would now seem inappropriate in what has become a multi-cultural society. However, the paper does indicate that there may be important cultural differences in factors that influence PND.

Parvin et al. (2004) discuss the experiences of Bangladeshi mothers in London and some findings were not unique to this ethnic group, for example with regard to not wishing to disclose feelings of depression. However, there were some cultural issues that may contribute to barriers to access to

health care. For example, there is a tendency to accept things. With regard to coping strategies, they say:

“The strategies mentioned such as praying to Allah or ‘keeping yourself happy’ relied on the woman’s ability to manage problems and emotional distress by herself.”,

and cite participants:

“There’s no point in talking about this problem because everyone has to do it, it’s what women need to do, they have to do it.”

“If sadness comes from inside, you have to put up with it” (Parvin et al., 2004. p. 256.)

There is also evidence that social class can influence how women respond to symptoms of PND. Counter to their expectations, Whitton et al. (1996) found that women in higher social classes were less likely to attribute symptoms to PND than those in lower social classes.

Black Caribbean women were reported to have some beliefs that may create barriers to accessing services. Edge et al. (2004) give their participants’ accounts of fearing that they are more likely to be labelled as mentally ill and having an enhanced belief in the need to cope independently and not seek or rely on help from others:

“I think it all relates to slavery ... We had to be strong for our kids ... we had to protect them... and it’s just been instilled into the daughters. You can’t depend on no man. ... *You* [emphasis in the original] have to be strong.”

“I’m very much aware that black people are more likely to be labelled as having psychiatric problems...” (Edge et al., 2004. p.434.)

However, other views were similar to those of the general population: that causes of depression are largely material (e.g. debt), not wanting to be labelled as mentally ill and the lack of knowledge about the nature of PND and what symptoms to look out for.

There may be barriers to accessing healthcare which are particularly pertinent to women in lower socio-economic classes. Murray et al. (2003) found that younger women with low educational attainment were less likely to take up support services offered. In discussion of provision for women with low levels of trust for others:

“When planning the provision of care for this group, services will need to be framed in culturally sensitive ways that directly address issues of psychological vulnerability if good take up is to be achieved. This may include approaches that limit the potential for recipients of care to feel patronized and blamed, but that engage with their lived reality and ideology.” (Murray et al., 2003. p.136.)

Women who had declined to participate in an intervention study offering early intervention were interviewed by Barlow et al. (2005). In discussing

why these vulnerable young women were not interested in taking part in the intervention, they noted:

“Many of these young women had only just left school or were still in education, and during the interviews displayed a low level of maturity and lack of ability, or willingness to relate to older adults.” (Barlow et al. 2005. p.203.)

They cite lack of trust as a barrier to women accessing support from health visitors. This is discussed further below, but one aspect of lack of trust may arise from the ‘social distance’ felt between the young women and the health professionals:

“...people should not go around professionally asking people how they are to say ‘there there dear, I’m sorry you feel upset’ - and they go back on with their smart life and their nice car, and their nice children, and their nice home, leaving me ...” (Sandra, Barlow et al. 2005. p.205.)

Health Service provision

A number of themes emerged that were related to the nature of service provision:

Identifying PND

Several papers refer to the failure of health professionals and mothers themselves to identify that there is a problem. Sometimes this may be due to poor screening methods as health professionals do not have the appropriate skills or time to pick up on women’s symptoms or, because the women themselves do not recognise their problem or, they may feel unable to reveal the full picture to health professionals.

For example:

“My mum phoned the midwife up and said “I don’t think [interviewee 1] is very well...” and the midwife said “oh she’ll be fine, it’s just a bit of anxiety”, and mum said “just stay here for an hour and see what she’s like”, but she said she was far too busy...” (Edwards & Timmons, 2005. p.476.)

“[mothers in her study who had developed PND]... felt that their illness had gone undetected by health professionals and the audit findings showed that psychological well-being of mothers in the postnatal period had not been addressed.” (Alabaster, 2000. p.40.)

“You see when the health visitor comes round, ‘Any problems?’ ‘No, everything’s fine.’ I mean it’s a classic isn’t it, you get someone

coming round to visit to make sure you're healthy and the baby's fine and 'Are there any problems?' 'Oh, no no no'. Again it's 'I can't take up your time, I'm not that important' type of thing, isn't it? It's the attitude of women and how we've been brought up not to make a fuss." (Tina p.168 in Mauthner, 1997)

In a study based on information from 78 women diagnosed with PND, Whitton et al. (1996) reported that over 90% of the women recognised 'something was wrong', but only one third of them attributed their symptoms to PND. Over 80% had not reported their symptoms to a health professional. This suggests that the inability to recognise symptoms is an important barrier to women seeking help. However, it is also of note that not all of those who recognised symptoms sought to access health care. The barrier created by difficulty for women in recognising their own symptoms was greatest for primiparous women.

Hipwell et al. (2004) focus on the potential of measurable antenatal cognitive factors in predicting PND. They found that antenatal self-devaluative tendencies did not predict depressive symptoms in the first weeks after delivery, but were predictive at 8 weeks:

"Given that self-devaluation is likely to be both a cause and a consequence of low mood (Teasedale, 1983), the lability of mood (the blues) that commonly occurs in the first week postpartum may serve to heighten the self-devaluative propensity of certain women. This may set in train the beginnings of a vicious cycle from which depressive symptoms emerge and become exacerbated over the postnatal period." (Hipwell et al., 2004. p.222.)

Such pre-markers of risk for PND could be incorporated in screening services that target support towards women most likely to need help. The authors of this review propose that self-devaluative tendencies are a plausible barrier to accessing mental health services as women with these perceptions feel 'unworthy' and may be less likely to 'trouble' health professionals with their worries. In their investigation of debt and social disadvantage as a predictor of maternal depression, Reading & Reynolds (2001) found that worry about debt was the strongest socio-economic predictor of depression (based on the EPDS scores) in their sample of mothers with infants under one year old.

The EPDS is generally reported as a useful screening tool in identifying risk of PND. There is a need to train health professionals in its use and to develop an equivalent tool for use in cultures and languages other than English (such as Punjabi, Clifford et al., 1997).

Roles of health Professionals

Several papers discuss the roles of various health professionals in identifying women with PND. In their review and discussion paper, Church & Scanlan (2002) question the appropriateness of reliance on midwives to obtain a thorough psychiatric history and potentially to prepare mothers for possible psychiatric morbidity without appropriate training and support. They challenge the idea that Community Psychiatric Nurses (CPNs) are the 'expert' perinatal mental health professional, arguing that CPNs have been encouraged to focus on people with severe conditions such as schizophrenia and they would need extra training and knowledge in order to work with mothers who are mentally ill. They go on to suggest appointing consultant midwives as leads in perinatal mental health to facilitate a multi-agency collaborative service.

There may be a perception among mothers that midwives are reluctant to address mental health issues:

“They say, ‘we don’t want to frighten you, we don’t want to give you too much knowledge, you’ve got enough to think about’ but surely it would be better if they gave you ... fewer basics on the labour and a bit more perhaps on what happens afterwards.” (Mauthner, 1997. p.166.)

Holden (1996) also observes:

“...not all health visitors either wish or feel able to work with depressed mothers.” (Holden, 1996. p.85.)

The role of health visitors in giving primary focus to child health and safety has already been mentioned in the 'Labelling' theme, where this was discussed as a possible barrier to women disclosing feelings of depression. Murray et al. (2003) offer more support for the idea that the role of Health Visitors is seen as potentially threatening and that the imbalance of power in the relationship can be an obstacle for women accessing help:

“Differences in many health outcomes are linked not so much to absolute levels of living standards, but to relative inequalities within societies, suggesting that sensitivity to differentials in status is important.¹⁶ Whether this process operated in the current study is unclear. However, it was striking, in the course of our research contacts, that women often commented that components of health care service felt inappropriate or alienating (e.g. discussion in antenatal classes of 'decorating the baby's room', and descriptions of Health Visitors as the 'Baby Police', a surveillance role well documented in other studies^{15, 17}).” (Murray et al., 2003. p.136.)

There is some debate about which health professionals are best placed to take a lead in the role of educating women, identifying PND and providing appropriate support and referral. Mauthner (1997) argues that:

“Finally, it seems appropriate to potentially expand the midwife’s (as opposed to the health visitor’s) role to include support in terms of the mother’s emotional and psychological well-being, given that the midwife’s focus is primarily on the mother rather than the child.” (Mauthner, 1997.p.170.)

However Wheatley et al. (2003) describe how midwives can feel apprehensive about broaching mental health issues with mothers and delivering a ‘diagnosis’ of PND. Their intervention in training midwives is reported as effective in boosting their skills and confidence in this.

Continuity of Care

One of the participants cited by Edwards and Timmons (2005) exemplifies how continuity of care can play a role in getting a problem diagnosed:

“I obviously needed some help... I think there should be more awareness because if it took the doctor to come round twice, the midwife everyday and the paramedics to not spot it, I just think it’s quite sad really that so many professionals couldn’t spot it and get me into hospital really, and in the end it was mum’s doctor, the family doctor who came out to see me and he admitted me right away because he knew I wasn’t like that normally.” (Edwards and Timmons, 2005. p.476.)

Better continuity of care for mothers with PND could be provided by extending the period of midwifery support:

“The very process of having to re-tell one’s “tale of woe” to subsequent professionals can in itself be draining, painful, and can increase the sense of stigma felt by the mother.” (Church & Scanlan, 2002. p.12.)

Mauthner (1997) also suggests expanding the midwives’ role to include more involvement in the postnatal period in order to improve continuity of care. She proposes that community based (rather than hospital based) antenatal groups could be extended into the postnatal period and provide continuity of support from other mothers.

Referrals

Mauthner (1997) acknowledges the role of midwives and health visitors in providing support for mothers themselves, but she also notes the competing demands on their time. Therefore, she suggests they can have an important role in referring mothers to other supportive health professionals or voluntary sector services:

“Cry-sis was very helpful because the whole emphasis is on talking to someone who’s been through it themselves and is able to reassure you a little bit that you are probably not doing anything wrong, it’s just the way the baby is... I’ve realised that what I was going through is something lots of people go through.” (Mauthner, 1997. p.169.)

Training for health professionals

Several papers highlight the need to improve training for health professionals responsible for providing information on PND, screening for PND (e.g. how to use the EPDS), referring women to other services and providing support. For example:

“If we are asking this group of professionals to take on a specific role in postnatal depression, we need not only their willingness and cooperation, but a standardised training programme,…” (Holden, 1996. p.85.)

“...a common training programme may be needed to provide a more consistent approach to identifying PND.” (Brown & Bacigalupo, 2006. p.51.)

“To better prepare themselves in identifying and supporting women with PND, all health visitors felt that they would benefit from further training and that this should include all members of the primary healthcare team” (Brown & Bacigalupo, 2006. p.51.)

Elliott et al. (2003) investigated the effectiveness of using trainer training for disseminating evidence-based practice for PND. They trained mental health workers to train midwives and health visitors in management of PND but found that some health visitors declined training and trainers often lost enthusiasm in the face of management difficulties. Hence they were unable to ascertain whether or not this form of intervention is valuable for health visitors’ involvement in PND.

Interactions between women and service providers

Trust

The issue of trust is linked to themes of 'labelling' and 'stigma' and 'roles of health professionals'. As already discussed, some women fear the diagnosis as a 'badge' of being a 'bad mother' or, at worst, resulting in the removal of their children into care or being 'sectioned'. This theme is linked to that of 'roles of health professionals' in that the child protection role of Health Visitors is seen as a barrier to accessing health care services. The 'lack of trust' theme identified by Barlow et al (2005) explains a potential reason why women do not disclose their concerns to health visitors preferring, in some cases, to have those intimate conversations within their family:

“... and unless you've got trust there it's a very difficult relationship to have because they're coming into your home, invading your space etc...” (Barlow et al., 2005. p.205.)

“I mean, I've got me mum here and she tells me what to do and that, so I don't know what a health visitor would do each week.” (Barlow et al., 2005. p.205.)

“... I didn't want to be truthful last time in case you locked me up!” (Pitts, 1995. p.145.)

Communication

Language issues can be a barrier to GPs identifying PND in black and ethnic minority women:

“Many of the GPs of the women were not aware that the women had PND, or that they had previously suffered with it. Often the language barrier meant that the GP simply could not get a firm enough understanding of familial circumstances to be able to offer help... Where support was desired, access and childcare facilities acted as barriers.” (Templeton et al., 2003. p.214.)

Intervention studies seeking to evaluate potential improvement of services often exclude non-English speakers, so they are not properly considered in trials (Wiggins et al., 2005.). This study itself did employ translators and a further paper is proposed to discuss this. One barrier to providing access to health care services to women who do not speak English is the restriction of the EPDS to the English language (see Identifying PND theme).

Mismatch between what women want and what is provided

Several of the papers suggest that women want more practical help rather than emotional support and that practical help, such as child-care facilities, would help women to access other services:

“In several cases the form of support desired was practical help with housework. The women at one of the groups said that leaflets were available to them but that face-to-face communication was lacking and there wasn’t enough information for the mother-to-be before birth.” (Templeton et al., 2003. p.214.)

“... They have nothing at their disposal to offer you by way of practical help - why do they ask how you are?” (Barlow et al., 2005.p.205.)

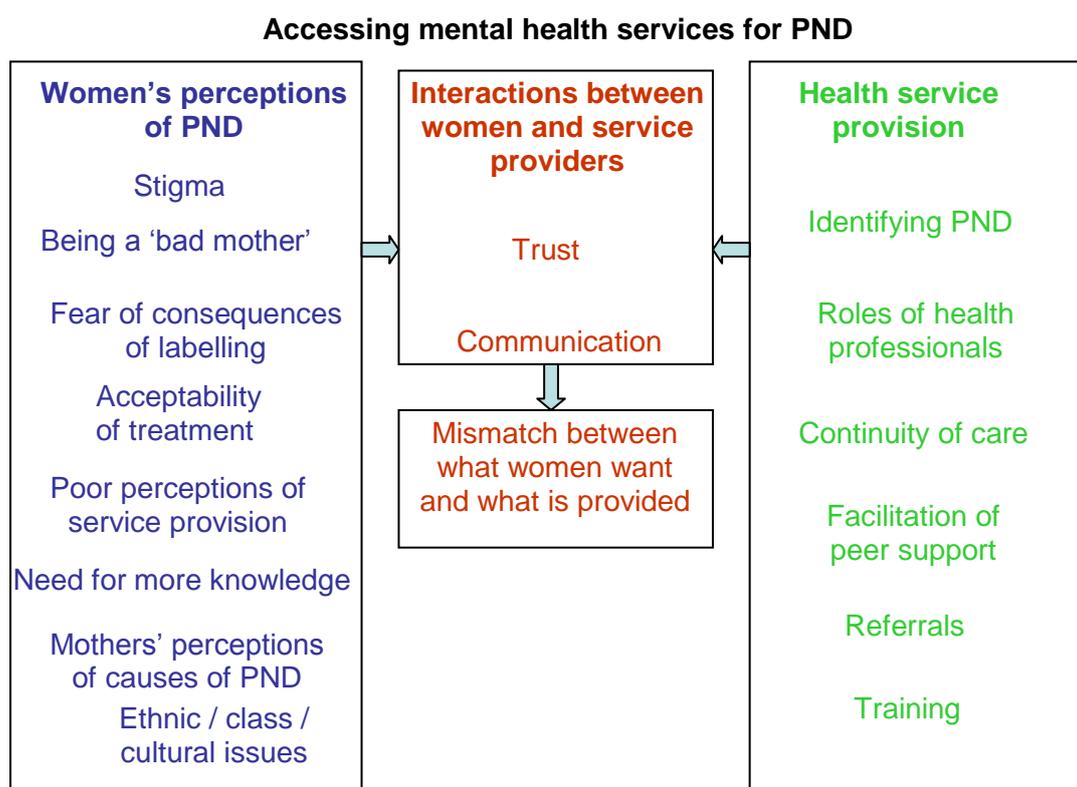
Murray et al. (2003) suggest the need for more culturally sensitive approaches that do not leave women feeling threatened or patronised.

Some interventions have found no benefit in terms of mental health outcomes, e.g. Morrell et al. (2000). There is a need to establish what is most effective and what women actually want and will find acceptable with regard to interventions.

Discussion

The relationships between the themes were discussed further, with a view to develop a theoretical model to propose how the categories work together to influence women’s access to health services for PND. Initial attempts to generate a diagram with arrows to signify links between constructs were fruitful in exposing a ‘web’ of relationships that potentially had reciprocal links between all possible combinations of themes. Whilst it was useful to discuss these inter-relationships, the diagrammatic model was too ‘busy’ to be helpful in clarifying points. However, through this process, two important themes emerged as ‘hubs’ that seemed to be implicated in linking many other themes together: the mismatch between what women want and what is provided; and identifying PND. These two ‘hub’ themes will be described further below.

Figure 2. Mismatch between what women want and what is provided:



The Health Service Provision and Women's Perceptions of PND themes both reflect the importance of the Interactions between service providers and women as follows:

Roles of health professionals can appear to be in conflict, for example the responsibility of Health Visitors for child protection may lead to lack of trust in the relationship and inhibit communication. It is important to identify which health professions are best suited to which roles. Also poor continuity of care can mean that a trusting relationship is not established, the health professions are unfamiliar with 'normal' behaviour and may not ask specific questions about PND. The Midwife may be well placed to do this given her/his contact before and after birth and good communication between health professionals leading to efficient referral of women is necessary to put them in communication with appropriate services. Well trained health professionals are required to have the appropriate skills and confidence to interact in a manner that is acceptable to women.

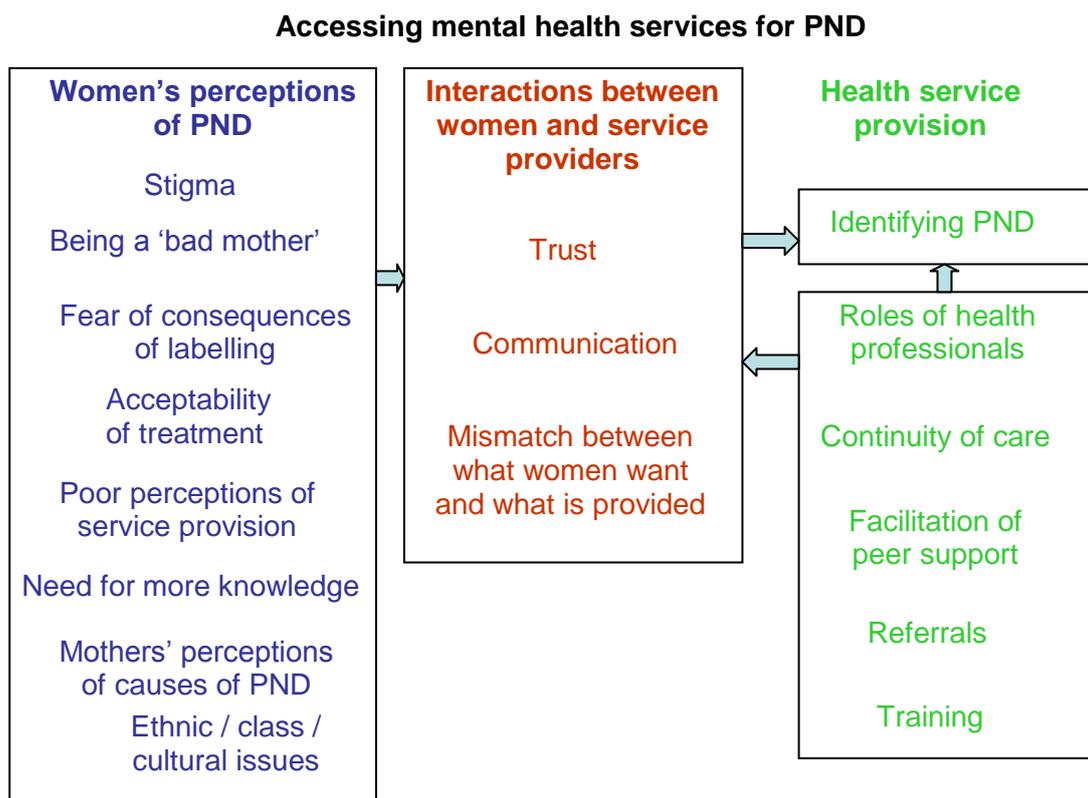
Stigma associated with mental illness and being a bad mother are clearly barriers to communication. The fear of the consequences of labelling and the potential for their child to be assessed as 'at risk' and taken into care also act as a barrier to trusting some health professionals. Furthermore, the treatments that women expect to be offered, or actually are offered, are sometimes unacceptable to them. For example the use of pharmacotherapy or 'talking' support; women do not want to continue in dialogue. Another

barrier can arise from women feeling that they lack sufficient knowledge of PND to interpret their symptoms: they do not know if they need to seek help. When PND is identified its causes are often perceived as social or material (stress of motherhood, debt, social deprivation etc.), so drug treatment and ‘talk’ are considered not to be helpful.

Women in different social groups need culturally and socially sensitive services in order to open good communication, e.g., information available in their language, acknowledging different cultural attitudes and beliefs about mental illness, and not appearing ‘socially distant’ or ‘authoritarian’.

The two groups of themes above determine the quality of trust and communication between women and service providers and in turn may result in a mismatch between what women think they need and find acceptable, and what the health services offer: women thinking that their depression is due to social and material circumstances and seeking practical help, while they perceive the health care services offer ‘only’ drugs and talk, which they do not believe will help.

Figure 3. Identifying PND



The failure to identify PND is a major barrier to women gaining access to the support service they need.

The interactions between health service providers play a role in mediating the effects of women’s perceptions of PND. For example stigma, fear of labelling and beliefs about treatment and service provision can colour trust

and communication with health professionals. They can produce a mismatch between what women think they need and what is on offer. In turn, this lack of trust, failure to disclose and lack of motivation to seek services that they do not believe will help, conspire together to block the identification of women who need health care services for PND.

Other aspects of service provision play a role in blocking the identification of women with PND. These can occur both directly and indirectly via effects on interactions between health professionals and women. An example of indirect influence is the way in which the role of health visitors can appear conflicted in their concern for mother and child (seen as the 'baby police') and can undermine trust and communication. This can create a barrier to identification of PND. There can be direct effects, for example, lack of continuity of care in services can result in health professionals failing to pick up changes in women because they are not familiar with them over a sufficiently long period. This issue of roles of health professionals is a complex one, with much debate over the roles of health visitors, midwives, GPs and CPNs.

The 'hub' themes of mismatch and identifying PND are challenging and raise questions: is what women want what they actually need, that is, what will resolve their PND? How can services and treatments be made more acceptable to women? What is the best way of screening for PND? Which health professionals should be involved and how? What training do these professionals need?

Conclusions

The review has identified a complex web of factors that are implicated in the creation of barriers to women accessing mental health services for PND. The findings section of this paper has provided a synthesis of research findings on the topic. The discussion section has gone on to further theorise around relationships between the themes and proposes two models that give an account of how the themes interact to describe and explain barriers to women accessing health services for PND. These models are theoretical, and require further testing. However they offer a means of linking disparate factors in a manner that may inform those concerned with removing the barriers to access of services for vulnerable women.

The issues relating to lack of trust and roles of health professionals are not intended to be critical of the many dedicated health professionals who work to support women who are at risk of, or suffering from PND, and achieve a great deal to help many women. This review is focussed on the barriers that prevent some vulnerable women accessing services and not the many women who do access services and receive excellent support and care.

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Appendix 1.

Search terms for each database.

Search strategy Medline 1966 -

Database: Ovid MEDLINE(R) <1966 to March Week 1 2006>

Search Strategy:

-
- 1 surestart.mp. (4)
 - 2 Sure Start.mp. (22)
 - 3 1 or 2 (26)
 - 4 post natal depression.mp. or exp Depression, Postpartum/ (1200)
 - 5 postnatal depression.tw. (609)
 - 6 postpartum depression.tw. (562)
 - 7 exp Depression/ (38795)
 - 8 depressive disorder\$.tw. (8150)
 - 9 depression.tw. (113993)
 - 10 Mothers/ or mothers.mp. (58597)
 - 11 7 or 8 or 9 (134968)
 - 12 10 and 11 (2251)
 - 13 4 or 5 or 6 or 12 (3386)
 - 14 exp Health Services Accessibility/ or access to healthcare.mp. (49219)
 - 15 access\$.tw. (130866)
 - 16 barrier\$.tw. (66161)
 - 17 uptake.tw. (159532)
 - 18 health services.mp. or exp Health Services/ (1037341)
 - 19 mental health service\$.mp. or exp Mental Health Services/ (50881)
 - 20 community health service\$.mp. or Community Health Services/ (20490)
 - 21 primary health care\$.mp. or exp Primary Health Care/ (45986)
 - 22 primary care.tw. (32660)
 - 23 15 or 16 or 17 (347567)
 - 24 18 or 19 or 20 or 21 or 22 (1070228)
 - 25 23 and 24 (35858)
 - 26 14 or 25 (74864)
 - 27 13 and 26 (57)
 - 28 13 and 3 (0)
 - 29 27 or 28 (57)

Psycinfo (Dialog) post natal depression

- | | | |
|---|---|------|
| 1 | post ADJ natal ADJ depression | 306 |
| 2 | postnatal ADJ depression | 1443 |
| 3 | POSTPARTUM-DEPRESSION#.DE. | 1456 |
| 4 | (postnatal ADJ depression).TI,AB. | 516 |
| 5 | (post ADJ natal ADJ depression).TI,AB. | 42 |
| 6 | (postpartum ADJ depression).TI,AB. | 646 |
| 7 | (post ADJ partum ADJ depression).TI,AB. | 58 |

8	(puerperal ADJ depression).TI,AB.		16
9	(post ADJ natal ADJ dysphoria).TI,AB.		1
10	(postnatal ADJ dysphoria).TI,AB.		1
11	1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10		2406
12	depression	163894	
13	depression.TI,AB.	94578	
14	MAJOR-DEPRESSION#.DE.		49030
15	(depressive ADJ disorder).TI,AB.	1980	9051
16	13 OR 14 OR 15	104730	
17	mother\$.TI,AB.	33262	
18	MOTHERS#.W..DE.		19549
19	17 OR 18	45809	
20	16 AND 19	3612	
21	20 OR 11	5229	
22	access ADJ to ADJ healthcare		2
23	HEALTH-CARE-UTILIZATION#.DE.		6741
24	(health ADJ service ADJ access\$).TI,AB.		15
25	22 OR 23 OR 24	6749	
27	access.TI,AB.	22425	
29	accessibil\$.TI,AB.		8
32	accessibility.TI,AB.		3301
33	barrier\$.TI,AB.	13313	
34	uptake.TI,AB.	3899	
35	utiliz\$.TI,AB.	12471	
36	utilis\$.TI,AB.	917	
37	27 OR 29 OR 32 OR 33 OR 34 OR 35 OR 36	1980	53613
38	(health ADJ care ADJ services).TI,AB.	1980	1153
39	HEALTH-CARE-SERVICES#.DE. OR PRIMARY-HEALTH-CARE#.DE. OR MENTAL-HEALTH-SERVICES#.DE. OR COMMUNITY-SERVICES#.DE.		43650
40	38 OR 39	44157	
41	37 AND 40	5860	
42	25 OR 41	11094	
43	21 AND 42 AND LG=EN		37

DH-DATA (Dialog) Post natal depression

Search history:

1	post ADJ natal ADJ depression	92
2	POST-NATAL-DEPRESSION#.DE.	82
3	postnatal ADJ depression	62
4	postpartum ADJ depression	6
5	post ADJ partum ADJ depression	4
8	postpartum ADJ dysphoria	0
9	post ADJ partum ADJ dysphoria	0
10	PUERPERAL ADJ depression	1
11	1 OR 2 OR 3 OR 4 OR 5 OR 8 OR 9 OR 10	108
12	depression	1542
13	DEPRESSION#.W..DE.	803

14	depressive ADJ disorders	77
15	12 OR 13 OR 14	1556
16	mother\$ OR maternal	3167
17	MOTHERS.W..DE.	758
18	16 OR 17	3167
19	15 AND 18	133
20	11 OR 19	188
21	access ADJ to ADJ healthcare	0
22	access\$ OR barrier\$ OR uptake OR utiliz\$ OR utilis\$	13033
23	access 6670	
24	ACCESS-TO-HEALTH-SERVICES#.DE.	1600
25	health ADJ services	22277
26	HEALTH-SERVICES#.DE. OR MENTAL-HEALTH-SERVICES#.DE. OR COMMUNITY-HEALTH-SERVICES#.DE. OR PRIMARY-CARE#.DE.	49759
27	25 OR 26	56039
28	22 AND 27	5922
29	24 OR 28	5922
30	20 AND 29	5

Kings fund (Dialog) Post natal depression

1	post ADJ natal ADJ depression OR POST-NATAL-DEPRESSION#.DE. OR postnatal ADJ depression OR postpartum ADJ depression OR post ADJ partum ADJ depression OR postpartum ADJ dysphoria OR post ADJ partum ADJ dysphoria OR PUERPERAL ADJ depression OR ((depression OR DEPRESSION#.W..DE. OR depressive ADJ disorders) AND (mother\$ OR maternal OR MOTHERS.W..DE.))	45
2	ACCESS-TO-HEALTH-SERVICES#.DE. OR (access\$ OR barrier\$ OR uptake OR utiliz\$ OR utilis\$) AND (health ADJ services OR HEALTH-SERVICES#.DE. OR MENTAL-HEALTH-SERVICES#.DE. OR COMMUNITY-HEALTH-SERVICES#.DE. OR PRIMARY-CARE#.DE.)	2991
3	1 AND 2	4

Assia - CSA Date Range: 1987 - 2006

((post natal depression) or (postnatal depression) or (post partum depression) or (postpartum depression) or ((depression or (depressive disorder*)) and (maternal or mother*))) and (access* or barrier* or uptake) and (health service* or mental health or community health service* or primary health care or primary care) 6

Embase 22/3/06

Database: EMBASE <1980 to 2006 Week 11>

Search Strategy:

- 1 exp Puerperal Depression/ or post natal depression.mp. or exp Puerperal Psychosis/ (1647)
- 2 postnatal depression.tw. (566)
- 3 postpartum depression.tw. (427)
- 4 post partum depression.tw. (68)
- 5 or/1-4 (1859)
- 6 depression.mp. or exp DEPRESSION/ (170552)
- 7 depressive disorder\$.tw. (8621)
- 8 6 or 7 (171002)
- 9 mother\$.mp. or exp MOTHER/ (72058)
- 10 maternal.tw. (73807)
- 11 9 or 10 (122321)
- 12 8 and 11 (3911)
- 13 5 or 12 (5074)
- 14 exp Health Care Access/ or access to healthcare.mp. (13918)
- 15 access\$.tw. (109041)
- 16 barrier\$.tw. (56968)
- 17 utiliz\$.tw. (144641)
- 18 utilis\$.tw. (12577)
- 19 uptake\$.tw. (141779)
- 20 or/15-19 (444626)
- 21 health services.mp. or exp Health Service/ (939215)
- 22 mental health services.mp. or exp Mental Health Service/ (11393)
- 23 community health services.mp. or exp Community Care/ (16608)
- 24 primary health care.mp. or exp Primary Health Care/ (32163)
- 25 primary care.mp. or exp Primary Medical Care/ (34197)
- 26 or/21-25 (944850)
- 27 20 and 26 (53874)
- 28 14 or 27 (62378)
- 29 13 and 28 (103)
- 30 limit 29 to (human and english language) (98)
- 31 from 30 keep 1-98 (98)

Cinahl (Dialog) postnatal depression

Search history:

1	post ADJ natal ADJ depression	104
2	DEPRESSION-POSTPARTUM#.DE.	991
3	(postnatal ADJ depression).TI,AB.	347
4	(postpartum ADJ depression).TI,AB.	330
5	(post ADJ natal ADJ depression).TI,AB.	19
6	(puerperal ADJ depression).TI,AB.	4
7	(postnatal ADJ dysphoria).TI,AB.	0
8	2 OR 3 OR 4 OR 5 OR 6	1069
9	depression.TI,AB.	13593
10	DEPRESSION#.W..DE.	14371
11	(depressive ADJ disorder).TI,AB.	609
12	9 OR 10 OR 11	19191

13	mother\$.TI,AB.	13020	
14	MOTHERS#.W..DE.	7037	
15	maternal.TI,AB.	8516	
16	13 OR 14 OR 15	21529	
17	12 AND 16	1213	
18	8 OR 17	1793	
19	(access ADJ to ADJ health ADJ care).TI,AB.		0
20	(health ADJ service ADJ access\$).TI,AB.		38
21	HEALTH-SERVICES-ACCESSIBILITY#.DE. OR HEALTH-SERVICES-NEEDS-AND-DEMAND#.DE. OR HEALTH-RESOURCE-UTILIZATION#.DE.		17869
22	20 OR 21	17886	
23	access\$.TI,AB.	19391	
24	barrier.TI,AB.	9722	
25	uptake.TI,AB.	2174	
26	utiliz\$.TI,AB.	13393	
27	utilis\$.TI,AB.	18469	
28	23 OR 24 OR 25 OR 26 OR 27	46051	
29	health ADJ services	96042	
30	MENTAL-HEALTH-SERVICES#.DE. OR PRIMARY-HEALTH-CARE#.DE.		25059
31	(community ADJ health ADJ services).TI,AB.		129
32	COMMUNITY-HEALTH-SERVICES#.DE.	108839	
33	(primary ADJ care).TI,AB.	11408	
34	29 OR 30 OR 31 OR 32 OR 33	189675	
35	28 AND 34	15326	
36	22 OR 35	27887	
37	18 AND 36 AND LG=EN	64	

Cinahl Sure Start - 22/3/06

Sure start or surestart.ti,ab. (81)

Web of Knowledge - Science Citation Index

(((((depression and (maternal or mother*)) or (postnatal depression or postnatal depression or postpartum depression or post partum depression or puerperal depression or puerperal dysphoria)) and (access* or barrier* or utiliz* or utilis* or uptake*) and (health service* or mental health service* or community service* or primary health care or primary care))))

Web of Knowledge Social Science Citation Index

(((((depression and (maternal or mother*)) or (postnatal depression or postnatal depression or postpartum depression or post partum depression or puerperal depression or puerperal dysphoria)) and (access* or barrier* or utiliz* or utilis* or uptake*) and (health service* or mental health service* or community service* or primary health care or primary care))))

Sociological Abstracts and Social Services Abstracts - CSA

((post natal depression) or (postnatal depression) or (post partum depression) or (postpartum depression) or ((depression or (depressive disorder*)) and (maternal or mother*))) and (access* or barrier* or uptake) and (health service* or mental health or community health service* or primary health care or primary care)

Medline in Process

**Database: Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations
<March 28, 2006> Search Strategy:**

-
- 1 postnatal depression.mp. [mp=title, original title, abstract, name of substance word] (27)
 - 2 post natal depression.mp. [mp=title, original title, abstract, name of substance word] (2)
 - 3 post partum depression.mp. [mp=title, original title, abstract, name of substance word] (4)
 - 4 postpartum depression.mp. [mp=title, original title, abstract, name of substance word] (37)
 - 5 puerperal depression.mp. [mp=title, original title, abstract, name of substance word] (0)
 - 6 or/1-5 (62)
 - 7 depression.mp. or depressive.tw. [mp=title, original title, abstract, name of substance word] (3680)
 - 8 mother\$.mp. or maternal.tw. [mp=title, original title, abstract, name of substance word] (3643)
 - 9 7 and 8 (129)
 - 10 6 or 9 (162)
 - 11 (access\$ or barrier\$ or uptake or utilis\$ or utiliz\$).mp. [mp=title, original title, abstract, name of substance word] (19421)
 - 12 (health care or primary care or community care or health service\$).mp. [mp=title, original title, abstract, name of substance word] (4278)
 - 13 10 and 11 and 12 (2)

Appendix 2.

Data extraction table:

	reference	Study population	Methods	Findings	Comments
	Alabaster, M (2000)	171 mothers attending clinic for 8m or 2yr assessment of child	questionnaire audit	<p>36% participating mothers had PND. It appears to have used the EPDS, but not explicitly stated.</p> <p>Training of HPs ‘But mental health issues are not covered in health visitor training, and neither are other essential tools such as basic counselling skills.’ P39. One of the responses was to provide training for health visitors on the EPDS.</p> <p>Failure to diagnose ‘These mothers felt that their illness had gone undetected, and the audit findings showed that the psychological well-being</p>	The paper reports on an Audit and changes made in response to findings. In discussion of why the women don’t seek help, it is not always clear which comments relate to the author’s own data, and which to another study: Holden, 1996.

				<p>of mothers in the postnatal period had not been addressed..' P.40.</p> <p>Information on PND One of the responses to the audit was to provide a booklet with information on signs and symptoms and a list of contact numbers. Mothers who suspect they have PND are encouraged to seek help as soon as possible. P.40</p>	
	Barlow et al., 2005	26 vulnerable women eligible for but who refused to take part in RCT of home visiting service for 6months pregnant to 1 year postnatal women.	19 interviews and thematic analysis, plus 7 responses to questionnaire.	<p>Reasons why women may refuse interventions Some women did not think they were vulnerable, so service not for them. Others were simply not interested. Some felt too burdened. Some had misgivings about benefits of service or lacked trust in the health visitor (professional) system. Some felt that their</p>	

				existing support network was sufficient. Some said that with hindsight, they now see that it may have been a good thing. There seems a mismatch between what was offered and what mothers think they require.	
	Brown & Bacigalupo, 2006	6 health visitors in 1 PCT area	semi-structured interviews	Four main themes: Visiting patterns. Training issues, identification of PND, (client relationship); barriers to identifying PND.	
	Chisholm et al., 2004	296 women recruited at antenatal clinics in 7 European centres, including London.	Questionnaires used pre and postnatally to measure depression, support and service receipt	There are wide differences in service provision across the countries, and access to and uptake of services in these sites is also varied, and often limited. They conclude that it is feasible to use the methods they piloted in the study to investigate service use.	The aim of this study was to develop a method collecting quantitative data. The number of participants in each centre was big enough for piloting measures, relatively small (N ranges from 20 to 60) for drawing wider conclusions.

	Church & Scanlan, 2002		Comment on 2001 Confidential enquiry into maternal deaths in the UK and consider current and future provision of mental health services by reviewing case studies.		
	Clifford, Day & Cox, 1997	Punjabi speakers on project team interpreted EPDS. 15 bilingual mothers in pilot study	Translating, back-translating, checking technical equivalence, piloting	EPDS should be accessible to the Punjabi population otherwise this group is excluded from referral using this widespread tool: <i>“the EPDS would be an appropriate tool for multicultural use. However, as this was only available in English, there was a need to consider ways in which this tool could be made accessible to the Punjabi-speaking population”</i> p616	Further validation to be carried out.
	Edge, Baker & Rogers, 2004	Women of white British (200) or black Caribbean (101) origin	Mixed method longitudinal cohort study. Antenatal	Black Caribbean women had more social risks for depression but less likely	Methodological issues were recognised: qualitative study was

		aged 18 or over, no learning disability, not receiving treatment for serious mental illness, literate in English.	questionnaires and postal questionnaires 6 weeks postnatally (130 White, 70 Black). Included EPDS + items relating to psychosocial risk for depression. Interviews with 12 black women when babies between 6 and 12 months, purposively sampled to include full range of EPDS scores and age, marital and SES and high and low life events. Thematic analysis using N4	to have above threshold scores on EPDS antenatally and less likely to have received treatment for depression. Categories including Support, Treatment, Personal agency and help-seeking, Labelling, Unfamiliarity, Service improvements all illustrated by the findings	only of those who consented to all 3 phases of the study; EPDS not validated in Caribbean women; qualitative results cannot be generalised
	Edwards & Timmons, 2005	6 women who had been in-patients on NHS mother and baby unit. All had diagnosis of severe postnatal mental illness – 3 puerperal psychosis, 2 severe postnatal depression, 1 depressive psychosis.	semi-structured interviews, data display, progressive focusing	Problems with recognition of their problem delayed diagnosis in these women. Stigma and labelling were problems. All had been treated and all were severely ill but barriers seemed to have been held up by the	The researcher had previous therapeutic relationship with interviewee but this was felt to be beneficial. Interview opens with question about stigma Feminist bias acknowledged. Progressive focusing

				healthcare professionals	process explained.
	Elliott et al., 2003	142 surveyed/112 returned from 42 health authorities. All were mental health professionals or primary care staff with some counselling training	Questionnaires to evaluate the efficacy of trainer training for disseminating evidence based practice for PND	Not all the trained trainers had gone on to train health visitors in their areas. Some health visitors declined training. Management had other priorities in some places.	This was an inconclusive assessment of a staff training intervention
	Foyster, 1995	mothers attending a support group	“evaluation”	Good to attend support group. Mothers felt fraudulent because didn't think they were depressed.	
	Hipwell, Reynolds & Crick, 2004	103 primiparous women recruited at parent-craft classes or antenatal clinics (9 excluded because above threshold for depression)	Interview, BDI prenatally, EPDS postnatally. Significant others scale, Parental bonding inventory, N scale of EPQ, depressed states checklist, autobiographical memory test given during last trimester of pregnancy (vulnerability), 7-10 days postpartum and	Suggests using a form of cognitive therapy prenatally with those identified as vulnerable	Discusses use of screening for self-devaluative tendency (pre-marker of PND) to target intervention to vulnerable mothers

			6-8 weeks postpartum (depressive symptomatology)		
	Holden, 1996	Review of work on health visitors' role	Narrative review of own group's work + some others	A small RCT of health visitor counselling c.f. routine primary care treatment of depressed women found sig. effect after up to 8 weekly sessions	The paper is mainly reviewing previous work. All are small studies which point towards the value of health visitors using the EPDS and some form of nondirective counselling and/or setting up self help groups. There are conclusions about the problems of health visitors taking on this extra work.
	Mantle, 2001		discussion of evidence for alternative medicine's efficacy	Mothers assume PND normal or don't want psychiatric history because of stigma. Some therapies good for some symptoms. Practitioners need to be aware	
	Mauthner, 1997	18 women who identified themselves as having experienced PND. all white, aged 20-39	Semi structured interviews lasting av. 3½ hours in 1 or 2 visits. Analysis using voice centred	Issues identified were associated with: Recognition, Training, Prenatal information, Unfamiliarity, Labelling,	

			relational method (Brown and Gilligan '92)	Midwife's role, Continuity of care.	
	McIntosh, 1993	60 first time mothers, 3 Glasgow antenatal clinics. All working class, ½ were 20 or under	6 semi structured interviews with each woman: prenatal and at 2 month intervals after the birth	Depression is commonplace. The majority do not seek help because they think it's threatening or inappropriate. Maybe health professionals should be more proactive. Needs of these women are not being met.	Method of analysis not specified, but appears to have used content analysis. Tables of prevalence etc. cited.
	Morrell et al., 2000	623 women aged 17 or over who delivered a live baby and lived in area served by community midwives at recruiting hospital (recruiting took place from 32 weeks pregnant).	RCT. All women were offered postnatal care from community midwives. Intervention group also offered 10 visits from support worker for up to 3 hours per visit in first 28 postnatal days. Postal follow up questionnaires at 6 weeks and 6 months	At 6 weeks: Control group had better self-perceived health measures: EPDS difference in favour of control group. More women reported supportive partner in intervention group. At 6 months; No differences in anything except cost (intervention cost).	Authors point out that the instruments may be inappropriate or insensitive. Need to establish those outcomes which mothers value.

			postnatal: SF36, EPDS, Duke functional support scale, rate of breastfeeding.		
	Murray, et al. 2003	Primiparous women identified antenatally as being at risk for PND. All were in a RCT of a preventive intervention for PND	Nested cohort case control study. 2 groups: agreed to extra visiting but received routine care (control group n=99); did not want intervention (self-exclusion group n=80)	figures on differences between participants in a trial and self excluders	This is all about differences between those who accept or don't accept services offered to them in a trial. All were identified as vulnerable for PND but there's no evidence that self excluders had any more or less psychological problems than control group.
	Newcombe & Gledstone, 2003		Essay on setting up and running groups for various people with common interests or problems	Not a research paper and no suggestion of any barriers	
	Parvin, Jones & Hull, 2004	Bagladeshi women in London (Tower Hamlets)	3 focus groups (n=10, 8 and 7) with mothers from 3 different community groups. All born in Bangladesh. Aged 21-54. Spoke little	Many Bangladeshi women cope alone and rarely seek help outside the family. There may be problems in understanding the role of GPs, midwives and	Focus groups were conducted in Sylheti, 'transcribed' in English and checked

			English. ‘Thematic content analysis’	health visitors beyond the physical. More language support needed to improve access to services.	
	Pitts, 1995	17 mothers identified as being vulnerable to or diagnosed with PND. 9 completed EPDS before and after attending	Description of group set up by health visitors for vulnerable or depressed mothers. Evaluation using EPDS before and after attendance.	Report on introduction of health visitor/mother group. Group method found to be cost effective in terms of health visitor time.	
	Reading & Reynolds, 2001	Families with infant under 12 months from 6 urban practices in Norwich. Moderately deprived populations.	2 postal questionnaires at beginning (261 families) and end (219). 209 completed at both times. Included EPDS (numerical scores included in analysis: correlations, multiple regression).	Close relationship between financial hardship and depressed mood in mothers	
	Templeton et al., 2003	6 black / minority ethnic group women with past or current experience of PND interviewed; ‘about a dozen’ women in focus	Interviews and focus groups. Thematic analysis.	3 main themes – issues specific to pregnancy and birth; issues specific to health care; issues specific to culture. They have a 4 th theme for ‘any	There is some lack of clarity on the numbers of people in the focus groups, method and analysis. The 3 broad themes are not broken

		groups (from mental health support groups). The abstract says data were also collected from GPs and health visitors who worked with these women. Located in Wiltshire.		other issues raised’.	down into sub-themes or structured. Some quotes are short and unattributed. The paper discusses some issues concerning problems of recruiting this group and getting them to do one-to-one interviews, problems of husband acting as translator, etc.
	Thorpe et al, 1992	165 Greek and 101 British mothers and their partners	Looked at relationship between mothers’ EPDS scores and measures of emotional wellbeing in pregnancy (CCEI), social support, life events, fathers’ EPDS scores and fathers’ perception of change in partner.	No difference in distribution of EPDS scores in 2 cultures and social support and life events were found to predict PND in both cultures. In Greece, emotional well-being in pregnancy made a separate contribution to prediction of PN emotional well-being. Difference in relationship between mothers and partners in 2 cultures – Greek fathers more emotionally and physically distance from	

				partner and perceived partner as more changed by transition to parenthood. These don't lead to differences in emotional well-being, possibly because the expectations of women are different?	
	Wheatley et al., 2003		Action research approach. Use EPDS to screen women and identify at risk women (score 12 or more) at 28 weeks antenatally, and invite them to participate. Women may receive intervention shortly before or after birth. Participants either visited at home or seen at SureStart centre. Seen once a week for 4 weeks. Agreed task set at visit and woman supported to achieve it and congratulated if	Data on interviews with people doing intervention reported – no EPDS data.	Method states they used Grounded Theory for analysis of interviews with midwives. They do not specify categories etc, but give extended quotes.

			achieves goal. After 4 weeks, follow up every 6 wks for 5-6 months.		
	Whitton, Warner & Appleby, 1996	78 mothers who were identified as depressed postnatally (using EPDS at 6-8 weeks and CIS-R) during recruitment to a treatment trial	Interview with open ended questions.. Method of analysis not specified but appears to be framework analysis.	51 had spoken to someone about symptoms, 9 of these to HCPs. 32 thought condition would resolve without treatment, 12 were afraid of addiction	Free to give own answers but main ones reported are yes and no. Results are given as frequencies of answer categories and chi square values.
	Wiggins et al., 2005	731 women from culturally diverse backgrounds with infants living in disadvantaged area	RCT with economic and process evaluations and follow-up at 12 and 18 months. 2 intervention groups and one control. Interventions were 1) a supportive health visitor; 2) community group and telephone support.	Little effect of interventions. At descriptive level, results best in supportive health visitor group followed by community group, but non-significant. Uptake of health visitor intervention much higher than community group (94% compared to just 19%)	