ADDRESSING ANXIETY AND DEPRESSION DURING PREGNANCY: PRIMARY ANTENATAL CARE PROVIDER PERSPECTIVES

by

Julia Santana Parrilla

B.A., The University of Alberta, 2011

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE

in

THE FACULTY OF GRADUATE AND POSTDOCTORAL STUDIES

(Population and Public Health)

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

April 2020

© Julia Santana Parrilla, 2020
The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, a thesis entitled:

Addressing Anxiety and Depression During Pregnancy: Primary Antenatal Care Provider Perspectives

submitted by Julia Santana Parrilla in partial fulfillment of the requirements for
the degree of Master of Science in Population and Public Health

Examining Committee:

Susan Cox
Co-supervisor

Hamideh Bayrampour
Co-supervisor

Paul Kershaw
Supervisory Committee Member

Gina Ogilvie
Additional Examiner
Abstract

This Thesis presents an Interpretive Description of twelve primary antenatal care providers’ (PACP) attitudes and perspectives towards anxiety and depression (AD) during pregnancy.

In British Columbia (BC), pregnant people (PP) can choose to be cared for throughout the perinatal period by a Family Physician (FP), Registered Midwife (RM), and/or Obstetrician-Gynecologist (ObGyn). Each profession operates under different mandates and care modalities. Thus, a purposive sample of twelve English-speaking PACPs (n=12) participated in one-on-one semi-structured interviews, including five FPs, four RMs, and three ObGyns. Interviews were transcribed verbatim and analyzed inductively using thematic analysis. Current practices in identifying and managing AD with PP, existing resources to support mental health during pregnancy, PACP’s perceived capacity to address AD during pregnancy, what could help address AD, and considerations for implementation in perinatal care settings are described. The knowledge constructed throughout interviews, analysis, and reporting portrays complex phenomena with significant implications for research, practice and policy.

Anxiety and depression (AD) in the antenatal period are associated with short and long-term morbidity for pregnant people (PP) and families. As the main and most constant point of contact with the healthcare system, PACPs are instrumental in shaping healthy pregnancy outcomes. With increasing calls to integrate mental health in perinatal care, this thesis explores and describes the perspectives of those on the frontline of care and offers insights to how we can improve responsiveness to needs. The latter focuses on organizational and system-level supports needed to facilitate the integration of mental health in perinatal care in the interest of healthy pregnancy outcomes.
Lay Summary

This qualitative study explored the attitudes and perspectives of twelve primary antenatal care providers (PACPs) in addressing anxiety and depression (AD) during pregnancy. In British Columbia (BC), pregnant people (PP) choose to be cared for throughout the perinatal period by a Family Physician (FP), Registered Midwife (RM), and/or Obstetrician-Gynecologist (ObGyn). Thus, I interviewed a purposive sample of five FPs, four RMs, and three ObGyns (n=12). This Thesis presents the Interpretative Description of participants’ attitudes and perspectives regarding AD during pregnancy, current practices to identify and manage them, and what’s needed to support perinatal mental health. In general, participants described complex phenomena whereby they encounter many barriers in addressing AD with PP. Ultimately, the need for organizational (e.g. hospitals) and system-level (e.g. health authorities) support in integrating mental health care in perinatal care was emphasized.
Preface

This Master’s thesis is an original, unpublished body of work performed by Julia Santana Parrilla. This project was approved by The University of British Columbia (UBC) Behaviour Research Ethics Board (BREB). The number of the UBC BREB certificate was H17-01672. Under the advisement of my Supervisory Committee, Drs. Hamideh Bayrampour, Susan Cox, and Paul Kershaw, I led this research study. Drs. Bayrampour and Cox were the co-Supervisors of this study.

This work was inspired by Dr. Bayrampour’s previous investigations into perinatal anxiety and screening.

As part of this research, I recruited perinatal care providers delivering primary antenatal care within Greater Vancouver and conducted semi-structured one-on-one interviews with them in the interest of garnering a deeper understanding of their attitudes and perspectives regarding anxiety and depression during pregnancy, those who experience it, and how to address it (identification and management). I created the interview guides in collaboration with my co-Supervisors. Dr. Cox’s prolific qualitative research career and Dr. Bayrampour’s perinatal expertise were constant resources in this work.

I independently analyzed the interview transcripts and wrote this thesis with the guidance of Dr. Susan Cox’s expertise, and feedback of my Supervisory Committee.

Recommendations herein were independently devised by Ms. Santana Parrilla as informed by Dr. Paul Kershaw’s proficiency in crafting actionable and sustainable knowledge-to-action strategies, and Dr. Bayrampour’s familiarity with perinatal care knowledge needs.
# Table of Contents

Abstract.............................................................................................................................................. iii  
Lay Summary....................................................................................................................................... iv  
Preface................................................................................................................................................ v  
Table of Contents ................................................................................................................................. vi  
List of Tables ......................................................................................................................................... x  
List of Abbreviations ........................................................................................................................... xi  
Acknowledgements ............................................................................................................................... xii  
Dedication ........................................................................................................................................... xiii  
Positionality Statement ......................................................................................................................... 1  

**Chapter 1: Introduction** ....................................................................................................................... 7  
1.1 Background ...................................................................................................................................... 8  
1.1.1 Why Primary Antenatal Care Providers? .................................................................................... 9  
1.1.2 Anxiety and Depression During Pregnancy .............................................................................. 13  
1.1.2.1 Social Determinant Considerations ..................................................................................... 17  
1.1.2.1.1 Healthcare as a determinant .............................................................................................. 19  
1.2 Knowledge-to-action: transformational intent .............................................................................. 20  

**Chapter 2: Methodology** ..................................................................................................................... 24  
2.1 One-on-one Interviews with Primary Antenatal Care Providers .................................................. 25  
2.1.1 Developing the Interview Guide ............................................................................................... 27  
2.2 Participant Engagement .................................................................................................................. 29  
2.2.1 Recruitment Methods ............................................................................................................... 29
2.3 Interview Analysis .................................................................................................................. 31
  2.3.1 Coding............................................................................................................................... 32
  2.3.2 Interpretive Description .................................................................................................... 34
  2.3.3 Knowledge-to-action......................................................................................................... 36
2.4 Trustworthiness ...................................................................................................................... 38
2.5 Ethical Considerations ........................................................................................................... 43

Chapter 3: Results .......................................................................................................................... 46

3.1 Introducing the Participants ................................................................................................ 46

3.2 Qualitative Findings ............................................................................................................. 47
  3.2.1 Attitudes and perspectives toward anxiety and depression within their practice .... 48
    3.2.1.1 It’s a common experience among their patients ......................................................... 49
    3.2.1.2 Pregnancy is a vulnerable time ..................................................................................... 50
  3.2.2 Attitudes and perspectives toward identifying anxiety and depression during pregnancy ................................................................................................................................. 51
    3.2.2.1 Through standardized screening ............................................................................. 52
      3.2.2.1.1 Perceived relevance and validity of screening tools ............................................. 52
      3.2.2.1.2 Perceived [potential] harms of screening using standardized tools ............... 55
      3.2.2.1.3 Using screening tools selectively ........................................................................ 56
    3.2.2.2 Through other means .............................................................................................. 57
      3.2.2.2.1 Using clinical judgement and seeing the signs .................................................. 57
      3.2.2.2.2 Relying on person-provider rapport for disclosure ........................................... 59
  3.2.3 Attitudes and perspectives toward anxiety and depression management during pregnancy ................................................................................................................................. 64
3.2.3.1 The need to tailor for relevance ................................................................. 64
3.2.3.2 The need to manage expectations and normalize emotion ....................... 66
3.2.3.3 What supports and resources exist to support mental health during pregnancy 69
3.2.3.4 “Then what?” and the perceived lack of supports for mental health during pregnancy .......................................................................................................................... 71
3.2.4 Attitudes and perspectives towards the gaps in care and primary antenatal care provider capacity to address anxiety and depression during pregnancy ............... 74
3.2.4.1 Gaps in training ............................................................................................... 76
3.2.4.2 Time and its role in gaps ............................................................................ 78
3.2.4.3 Gaps and the responsibility to fill them ....................................................... 80
3.2.5 Attitudes and perspectives towards what could help address anxiety and depression during pregnancy .......................................................... 82
3.2.6 Attitudes and perspectives towards knowledge implementation in primary antenatal care settings ................................................................. 84
3.2.6.1 “Make it easier” to implement new knowledge, care recommendations and strategies in primary antenatal care settings ............................................ 87
3.2.6.2 Motivations to change .................................................................................. 90

Chapter 4: Discussion ............................................................................................... 94
4.1 Identifying anxiety and depression during pregnancy ........................................ 95
4.2 Managing anxiety and depression during pregnancy ........................................ 100
4.3 Knowledge-to-action ....................................................................................... 102
4.4 Recommendations ........................................................................................... 105
4.4.1 Funding mental health care ........................................................................ 105
4.4.2 Improving access to pregnancy-specific mental health resources .................. 107
4.4.3 Integrating mental health in perinatal care................................................. 110
4.5 Strengths and limitations............................................................................... 113
4.6 Conclusions................................................................................................... 119

Bibliography ........................................................................................................... 121

Appendices.............................................................................................................. 140

Appendix A : Research Proposal Objectives ...................................................... 140
Appendix B : Informed Consent Form ................................................................. 142
Appendix C : Case Study Vignette ........................................................................ 146
Appendix D : Interview guide................................................................................ 147
Appendix E : Recruitment email........................................................................... 150
Appendix F : Recruitment presentation slideshow and presentation guide ........... 152
  F.1 Guide............................................................................................................... 152
  F.2 Presentation; PowerPoint................................................................................ 153
Appendix G : Recruitment cards .......................................................................... 155
Appendix H : Interpretive Description Narrative Exercise (Sally Thorne, 2008). ....... 156
Appendix I : Comprehensive table of interview data ............................................ 157
Appendix J : Inventory of mental health service and resources ............................ 180
  J.1 For dissemination............................................................................................ 180
  J.2 Care support and pathways participants relied on .......................................... 182
List of Tables

Table 3-1 - participant overview

................................................................. 47
List of Abbreviations

AD = Anxiety and/or Depression

PP = Pregnant People

PACP = Primary Antenatal Care Provider

FP = Family Physician; M.D.

ObGyn = Obstetrician Gynecologist

RM = Registered Midwife

BC = British Columbia

EPDS = Edinburg Postnatal Depression Scale

RMH = Reproductive Mental Health

MH = Mental Health
Acknowledgements

This work and my journey through it were made possible by the ongoing support of people in my professional, academic, and personal lives. Their encouragement has been integral to the development and sustainability of my self-compassion in undertaking this independent work.

I offer thanks to the participants of this study who took time from their busy professional lives as perinatal care providers to share their insights and reflections with me. Without financial incentive, and over a year of recruiting, these twelve individuals are the generous champions of this work. Their contributions are invaluable.

To my Supervisory Committee, thank you for your guidance, patience, and trust. You took a chance on me and I am forever grateful for your encouragement and support. From its inception to this final piece, you have emboldened my creativity while grounding my aspirations. My gratitude is endless.

To my loved ones, you have been my lifeforce, always.

Madre & Padre, gracias por apoyarme durante estos años. Aprecio los sacrificios que han hecho a lo largo de mi vida para que pudiera llegar aquí. Son mi inspiración.

Elena, gracias por disipar cada duda que he tenido. Agradezco todo lo que sigues enseñándome, ¡aliada de mi vida!

Clinton, amore, thank you for holding my hand through these years fraught with growth and the challenges therein. Whatever is next, I am honoured to approach it with you.

To my friends, the spaces you have offered me to explore my passions over these years have been indispensable. From my most doubtful to my most prideful moments, you have offered your love to me, and I am deeply privileged to receive it. Thank you.
Dedication

To all those bringing forth and nurturing our future generations

“There is no such thing as a single-issue struggle because we do not live single-issue lives.”

– Audre Lorde

Black American Writer, Feminist, and Civil Rights Activist
Positionality Statement

“We must act as if we answer to, and only answer to, our ancestors, our children, and the unborn.”

– Amilcar Cabral

Black Intellectual, Poet, Anti-Colonial Leader

I interpret Cabral’s words as: we all have a social responsibility to be aware of and accountable to those whose lives are disproportionately impacted by socio-historical systems of oppression, and to leave this world better than how we found it.

I approach the writing of this thesis as a social scientist and community advocate, aiming to present the issues and their meanings in ways that activate the reader. That’s to say, my intention is that when you finish reading this thesis, you have a profound sense that something needs to be done, and that you feel inspired by the opportunities I identify to make changes. My hope is that this positionality statement will aid you in following my Interpretive Description undertaken and presented in this Thesis.

As the research instrument, my world view, values, and biases play a meaningful role in shaping the nature and outcomes of my work (Sally Thorne, 2008). In this positionality statement, I reflect critically on how who I am and what I stand for have shaped this research project, from its design to its reporting. As Sally Thorne (2008) put it: “Because, as a researcher, your mind and your personhood are integrally involved in what you will accomplish, it is only with some honest reflection on these elements that you can ensure that the research products you generate are true to your purpose and become meaningful empirical contributions.” (Thorne, 2008, page 64).
Together with the practice of memo-writing, my constant reflections on my position relative to this work, those involved in it, and the eventual audience of its outcomes served as built-in strategies to keep myself on track with the ultimate purpose of this project as it evolved. This “reflexive accounting” (Sally Thorne, 2008) lends itself to the trustworthiness of the findings and recommendations shared.

**My Perspective:**

Throughout my twenties, I familiarized myself with social-constructivist and postmodernist paradigms, informed by queer studies, intersectional feminism, and anti-racism. All along, I have been challenged by an expanding worldview; one that has given names to supremacy in its many forms, and with that, a recognition of my position within them. As such, I reflect on the role of power, knowledge, and the re/production of dominant structures (policies, practices, etc.) in marginalizing or privileging particular populations as maintained by a cultural status quo (Tilley, 2016). Thus, it is my opinion that when working toward health equity, it is imperative we speak to how Canada and our institutions (including academia and healthcare) are built on and maintain supremacy. For instance, our ways of learning and knowing are euro-centric, patriarchal, and ableist. With that, we erase the perspectives and experiences of racialized peoples (including Indigenous, First Nation, Inuit and Metis) and to this day, we are missing clinical trials that investigate how healthcare interventions result in disparate outcomes based on race, gender, dis/ability, etc. The cisgender able-bodied neurotypical white man’s body has been the baseline, and his mind privileged, always.

When we do not acknowledge sociocultural factors such as these, we are inevitably propagating supremacy and with it health and social disparities. Health inequities indicate how our healthcare centers oppressive systems that perpetuate harms rooted in supremacy. As a
person who has been educated in Canada, I also recognize how its systems have conditioned my attitudes, perspectives and values, resulting in biases I am responsible for.

In approaching this investigation, I considered myself an outsider to this area of inquiry, those it impacts, and who is involved. Essentially, I am neither a perinatal care provider nor a parent. That said, my familiarization with the evidence base concerning perinatal AD, and seven years of volunteer experience in antenatal care settings have facilitated a sense of competence and confidence in conversations with both the providers and receivers of perinatal care. From 2012-2019, I volunteered as a Recreation Therapy Assistant at the women’s hospital antenatal care ward with pregnant people (PP) on in-hospital bedrest. On a weekly basis, I aided the Recreation Therapist in guiding PP through creative activities. This program was offered to draw PP out of their rooms and into a shared space to minimize the isolation and stress of being in-hospital. Some of the PP were brought in from rural and remote areas of BC, far from their comforts and systems of support. Throughout these seven years, I heard all manner of stories as PP commiserated; all with a common thread: anxiety. A combination of unknowns, restricted agency (in-hospital rules) and a steadfast focus on their baby/ies’ wellbeing (prioritized over their own) culminated in much stress, anxiety, and depressed mood among PP. My interactions with the people who attended our sessions have had lasting impacts on how I think about perinatal care. Namely, that it is a disservice to all PP that mental health is not integrated in perinatal care. To me, this indicates significant shortcomings in the status quo regarding PP in society; more than vessels for the next generation/s, PP’s perinatal care should not be exclusive to their physiology and gestation (focusing on the growth of baby/ies).
Cumulatively, my constructivist paradigm, intersectional feminist perspective, familiarization with the literature concerning AD during pregnancy, and volunteer experiences, I have accrued insights and garnered empathy that shaped how I approached this investigation. Throughout this work, I carried assumptions that shaped my perceptions and interpretations of the work undertaken. My greatest challenge has been to quell any inkling of confirmation bias. That’s to say, that I had to remain cognizant of projecting meaning onto participants’ responses that confirmed my beliefs that the system is failing PP experiencing AD and that PACPs have the power to do something about it. This was ever-present in my mind when conducting interviews and analysing data (tracked in reflexive memos). In the former, I endeavoured to follow the participants where they took me as they reflected on the open-ended questions I posed, mindful of probing minimally and only in ways to expand on what they had already shared. We were co-creating knowledge; as the interviewer I was in control, but I didn’t want to lead it in any way. In the analysis, I leaned into my critical brain, but would ask myself “am I problematizing something that my participant is not reflecting on as problematic?” Without lived experiences as a PACP nor a person receiving perinatal care, I cannot presume to be an expert in either. Thus, I recognize that my participants’ experiences are filtered through my biases and unknowns in being a nulliparous, settler, able-bodied, educationally privileged, cisgender woman.

This study explored what is needed to better address anxiety and depression (AD) during pregnancy from the perspective of those on the frontlines of care: primary antenatal care providers (PACPs). The purpose being to identify and describe ways to lessen the burden of perinatal mental health on pregnant people (PP) and their families, care providers (PACPs) and their dyadic relationships (PP-PACP), and our health organizations, authorities and systems. As I familiarized myself with the literature on perinatal mental health, I was led toward some
assumptions regarding the role of PACPs in addressing the issue. I perceived them to be in the unique position to impact health outcomes and shift the cultures of the spaces they work in (with eventual implications for the healthcare system). I viewed them as actors inside a structured system, and champions and advocates of/for their patients’ wellbeing (and still do). So, at the outset, my idea was to develop a strategy to support PACPs in addressing AD so that: (1) PP would experience happier and healthier pregnancies, minimizing adverse outcomes for them, their babies, and families; (2) the integration of mental health in perinatal care would have micro beginnings; (3) a growing base of providers would put pressure on systems to integrate mental health. In other words, I thought that if PACPs had the support, they could put pressure on the system to integrate MH while improving health outcomes in their settings. However, as interviews went on, the assumptions underlying this idea were challenged significantly and by the time I was ready to report the findings, I found PACPs negotiate their power and capacity to catalyze change (in the individual, dyadic, clinical, and system levels) relative to the system they provide services in. Even though they are the ones with the power in their clinical settings and dyadic relationships with PP (care delivery is inherently paternalistic; the service provider is the expert knower), PACPs operate under structures and mandates that limit the resources they have to mobilize toward addressing AD during pregnancy.

I entered this work thinking that – as representatives of our system and values – PACPs are on the frontlines of ensuring sustainable, equitable, and quality healthcare. I figured that if PACPs had access to appropriate support strategies, more cases of AD during pregnancy would be addressed. So, the impetus of this project was to investigate how to do that. Ultimately, my assumptions about PACPs’ roles in the transformational intent of this Thesis investigation were dispelled by participants. Reflexive memoing was integral to catching my biases and
assumptions, and instrumental in arriving at a shared vision with my participants. Consequently, my Interpretive Description dedicates special attention to the nuances in participants’ reflections and aims to honour the integrity of their experiences. Altogether, I present a bigger picture than anticipated that elevates participants’ attitudes and perspectives toward perinatal care transformation.

Although I no longer view PACPs as having the power to drive this change, perinatal care still offers unique opportunities to catalyze the integration of mental health into our healthcare systems, policies, services and practices; indeed, I believe it could lead the way! Not only is pregnancy a time of great stress, but also a time of continuous contact with healthcare. The system needs to minimize health disparities by supporting and lessening the burden on PACPs and PP to manage mental health concerns during pregnancy. I end this thesis offering suggestions for action informed by the barriers and priorities identified by participants.
Chapter 1: Introduction

This Thesis presents the Interpretive Description of a qualitative study designed to garner a deeper understanding of how Primary Antenatal Care Providers (PACPs) identify and support pregnant people (PP) experiencing anxiety and depression (AD), as well as explore ways to better support PACPs in doing so. My objectives were to investigate PACP attitudes and perspectives pertaining to: (a) anxiety and depression during pregnancy; (b) barriers and facilitators to identifying and supporting (i.e. screening, referral, management) pregnant people experiencing anxiety and/or depression during pregnancy; (c) determinants of knowledge implementation in perinatal care settings.

Perinatal AD are known to have negative impacts on pregnancy and birth outcomes with short- and long-term effects on PP and their families’ health (Beijers et al., 2010; Dunkel Schetter & Tanner, 2012; Kofman, 2002; Mulder et al., 2002; Shahhosseini et al., 2015; Skouteris et al., 2009; A. Staneva et al., 2015; Wadhwa et al., 2002). Currently, mental health care is often not integrated in perinatal care. Consequently, the needs of PP experiencing AD are unmet and health disparities persist. There is much to be done regarding mental health equity for PP. This study responds to Krupel & Wichman (2017)’s assertion that further research is warranted regarding how an integrated model can more positively affect perinatal health outcomes by supporting PACPs in addressing AD during pregnancy (from identification, management, and/or referrals) (Kruper & Wichman, 2017).

This project is the first of its kind in British Columbia (BC) and offers recommendations to address the inequities experienced in pregnancy care and family health outcomes. A total of twelve PACPs were interviewed (n=12), including five Family Practitioners, four Registered Midwives, and three Obstetrician/Gynecologists. Although specific to BC, the knowledge
discussed herein has implications from the local (health authorities), to provincial (ministry of health) and federal levels.

1.1 Background

Perinatal mental health is considered a global public health issue (WHO | Maternal mental health, n.d.). Mood and anxiety disorders are the most common types of mental illness locally and globally (Canada, 2016b). Anxiety and depression (AD) occur more frequently among women than in men (Canada, 2016b; Gobinath et al., 2015; Weissman & Olfson, 1995). This lifetime prevalence is seen across cultures and most often manifests during reproductive years (Weissman & Olfson, 1995), particularly during times of dramatic hormonal fluctuations (Hendrick et al., 1998), such as during pregnancy and postpartum. Approximately one in three women may experience anxiety symptoms during pregnancy (Lee et al., 2007) and 8-12% of women experience depression during pregnancy (BC Reproductive Mental Health Program, n.d.) – both known causes of chronic disability (Stewart, 2011). Indeed, the leading cause of disability in Canada is mental ill-being (Lim et al., 2008; Mental Health Commission of Canada, 2014b). Not only are people with chronic medical conditions more likely to experience mood disorders (including AD), but people with mood disorders are at higher risk of developing long-term medical conditions (Patten et al., 2005). These health outcomes result in life-altering impairments that burden Canadians and our healthcare system due to high levels of health care service utilization and the health costs associated with them. In Canada, the economic burden of mental illness is an estimated $51 billion per year (Lim et al., 2008; Smetanin et al., 2011).

Locally, Perinatal Services British Columbia recognizes that early detection of mental health challenges during the antenatal period offers opportunities to improve health outcomes for parents and families (BC Reproductive Mental Health Program & Perinatal Services BC, 2014).
Unfortunately, the identification and treatment of anxiety and depression (AD) in the antenatal period has been largely neglected in research (Akiki et al., 2016; Bennett et al., 2004; Dunkel Schetter & Tanner, 2012; Kimmel et al., 2019; Skouteris et al., 2009; Spiers et al., 2013, Chapter 16) and care priority setting (Kimmel et al., 2019), particularly prenatal anxiety (Dunkel Schetter & Tanner, 2012; Skouteris et al., 2009). For example, in a 2017 report on key perinatal health indicators from the Canadian Perinatal Surveillance System, mental health was mentioned once (in reference to maternal morbidity) (Public Health Agency of Canada, 2017). Only recently have investigations into the etiology, prevalence, identification and management of AD been undertaken (Avni-Barron & Wiegartz, 2011). The lack of mental health integration in perinatal health research and care perpetuates health disparities as antenatal AD have been associated with short- and long-term adverse outcomes in parents and their children alike (O’Hara & Wisner, 2014; Shonkoff et al., 2012; Spiers et al., 2013, Chapter 16).

1.1.1 Why Primary Antenatal Care Providers?

As the main and most constant point of contact with the healthcare system for parents, PACPs are instrumental in improving pregnancy health outcomes (Price et al., 2012). In British Columbia (BC), people choose to be cared for by a registered midwife (RM), family physician (FP), or obstetrician-gynecologist (ObGyn) throughout pregnancy, birth and postpartum (HealthyFamiliesBC, n.d.). Although we can speculate that all PACPs have vested interests in pregnancy health outcomes, each provider group operates under different mandates, care delivery approaches, and will have disparate professional interests. Familiarity with each group’s barriers/facilitators to addressing mental health during pregnancy is essential to minimizing the short-/long-term burden of disease on individual, dyadic (patient-provider), and system-levels (Misra & Grason, 2006; Price et al., 2012). PACP perspectives illustrate salient insights to
barriers/facilitators to the improvement of Canadian perinatal health outcomes, and the efficiency and comprehensiveness of care/service provision. Understanding PACP perspectives regarding how and why AD are not being addressed in their care settings (identified and managed effectively) offers critical insights to our systems, and identifies opportunities for transformation.

There is a growing knowledge base that explores provider factors in the identification and management of AD during pregnancy. For instance, in 2018, Bayrampour et al. conducted an integrative review of barriers to addressing mental health concerns in midwifery settings and found that time constraints and pressures, skepticism toward mental health as warranting management and resistance toward screening, a lack of general knowledge and formal training regarding mental health, and inadequate awareness of referral pathways (and resources/services) were among the most commonly cited reasons mental health concerns remain unaddressed (Bayrampour et al., 2018). Similarly, Price et al. (2012) found that inadequate time, available management services, incentivization, and knowledge were the most common barriers to PACPs responding to perinatal depression (Price et al., 2012). In 2009, Kim et al. reported that obstetric care providers (19 obstetricians and 3 nurse midwives) encountered much frustration in screening for perinatal depression. Namely, with a lack of established protocols to address perinatal depression and mental health referrals not resulting in treatment (Kim et al., 2009). Indeed, the gap between identification and management – specifically, the link between screening and accessing treatment through referrals – is a consistent issue identified in the literature (Ford et al., 2017; Price et al., 2012). Consequently, although PACPs recognize the value of identifying mental health concerns, the implementation of screening has been a challenge.
These organizational barriers are further exacerbated by the siloing of approaches to addressing perinatal mental health (Selix et al., 2017). In other words, perinatal mental health is a multidisciplinary and intersectoral concern wherein there are multiple actors and opportunities to prevent, identify, and/or manage cases of AD during pregnancy, but at present they are not working together (e.g. obstetrics, mental health services, infant health) (Selix et al., 2017). Although PACPs recognize their role in addressing perinatal mental health concerns, they are lacking the resources (e.g. training and time) to do so (Bayrampour et al., 2018; Price et al., 2012). Generally, supportive attitudes toward addressing AD during pregnancy among PACPs have been found to be “insufficient as a motivator” (Kim et al., 2009). Rather, confidence has been found to be a significant predictor of identification and management of mental health concerns by PACPs (Ford et al., 2017; Price et al., 2012). Confidence could be bolstered via increased knowledge and training, increased awareness of resources and pathways to access them, and multidisciplinary collaboration (Ford et al., 2017; Gerdes et al., 2001). According to Gerdes et al. (2001), clinicians, policymakers, and academics have been advocating for primary care and mental health care collaboration (i.e. pathway to integration) since the 1960s (Gerdes et al., 2001). Indeed, although perinatal care offers opportunities to address AD during pregnancy, given the complexity and uniqueness of every PP’s AD, multidisciplinary action has been recommended (Gerdes et al., 2001; Hoffman & Wisner, 2017; Kimmel et al., 2019).

Cumulatively, the evidence that exists detailing PACP perspectives about addressing AD during pregnancy portray complex phenomena. Consequently, I set out to understand PACPs’ current practices in addressing AD during pregnancy (including barriers and facilitators) as well as their knowledge needs and implementation contexts (knowledge-to-action). Based in the literature, my study was designed under the assumptions that: (a) pregnant people have limited
involvement in decision-making and are unlikely to voice concerns (D. E. Kingston et al., 2015; Thompson & Miller, 2014); (b) the continuous nature of perinatal care presents ample opportunity to identify and support pregnant people experiencing AD; (c) an understanding of care provider barriers/facilitators to addressing AD during pregnancy could inform efforts to improve pregnancy health outcomes; (d) insights to knowledge-to-action in their clinical settings could clarify pathways for mental health integration in perinatal care. Ultimately, I considered PACPs to be responsible for engaging pregnant people in their care, integrating evidence-based clinical knowledge and their own experiential knowledge to build patient-centered partnerships in the development of management plans (Pomey et al., 2015).

As representatives of our healthcare system and values, PACPs are on the frontlines of ensuring sustainable, equitable, and quality healthcare. Reciprocally, front-line care providers have been identified as integral to shaping health outcomes and the initiatives and policies that impact them (Price et al., 2012; Selix et al., 2017). This is an onerous responsibility that requires inter-social, inter-professional, and inter-sectoral engagement with collaborative and iterative relationship building from community to policy levels. Still, PACPs are in the unique position to leverage their expertise to raise awareness and generate change to better support Canadian pregnancy health outcomes, and the efficiency and comprehensiveness of perinatal care/service provision. It is important to understand how to incentivize and support PACPs in catalyzing change to prevent avoidable pregnancy outcomes like: post-partum depression; preterm labour; low birth weight, and subsequent developmental challenges (Avni-Barron & Wiegartz, 2011; Bayrampour et al., 2015; Dunkel Schetter & Tanner, 2012; Goodman & Tyer-Viola, 2010; Hoffman & Wisner, 2017; D. E. Kingston et al., 2015; Skouteris et al., 2009) including respiratory illness (Beijers et al., 2010) and neurodevelopmental problems (Avni-Barron &
Wiegartz, 2011; Dunkel Schetter & Tanner, 2012; Shahhosseini et al., 2015), as well as maternal suicide and infanticide (BC Reproductive Mental Health Program & Perinatal Services BC, 2014; Cook et al., 2017; Hoffman & Wisner, 2017; Kimmel et al., 2019; Public Health Agency of Canada, 2017). Investigating PACP perspectives holds the promise to contribute to our healthcare system’s responsiveness to the needs of our citizens.

1.1.2 Anxiety and Depression During Pregnancy

The relationship between anxiety and depression exacerbates symptoms in both and considerably worsens health outcomes and the quality of life of those experiencing them (Furtado et al., 2019). The comorbid nature of AD in the perinatal period has its inception during pregnancy (Bayrampour et al., 2016; BC Reproductive Mental Health Program, n.d.); antenatal anxiety has been shown to predict postpartum depression, and antenatal depression is a risk factor for postpartum anxiety (and its worsening) (Furtado et al., 2019). In 2015, Vancouver-based investigators, Fairbrother, et al. found that the two strongest risk factors for postpartum depression are AD during pregnancy (Fairbrother et al., 2015). The comorbid relationship between anxiety and depression during pregnancy has been established (Fairbrother et al., 2015; Furtado et al., 2019; Gobinath et al., 2015; Kimmel et al., 2019; Reissland et al., 2018; A. A. Staneva et al., 2015; Yim et al., 2015), with an estimated 50% of women experiencing perinatal depression also suffering from clinically significant anxiety (Ross et al., 2003). In British Columbia (BC), up to one in five women will experience significant depression associated with pregnancy and childbirth (BC Reproductive Mental Health Program, 2006). This is significant as many studies have reported on the higher prevalence of comorbid anxiety disorders and atypical depression among women (Gobinath et al., 2015; Reissland et al., 2018) and depression is the leading cause of disability among women in their childbearing years (BC Reproductive Mental
Health Program & Perinatal Services BC, 2014; Kessler et al., 2005). Additionally, compared to non-perinatal women, perinatal women experience higher mean levels of mood fluctuations (depressed, irritable, anxious and mood instability) (Bowen et al., 2012). Indeed, as compared to members of the general population with anxiety, rates of anxiety have been found to be higher during the perinatal period (3-5% vs 4.5-8.5%, respectively) (BC Reproductive Mental Health Program, n.d.).

The perinatal period has been associated with significant and unique changes – including biological, social, and psychological – that are brought on and internalized differently by every PP (Kimmel et al., 2019) and associated with alterations in brain function that manifest as unstable moods (Bowen et al., 2012). Anxiety during this time has been defined as excessive worry and fear regarding pregnancy, and parenting (Bayrampour et al., 2016), including fears and anxieties specific to the baby’s wellbeing, labor and delivery, ability to breast feed, financial worries and changes in relationships (BC Reproductive Mental Health Program, n.d.). The journey toward parenthood is a time of transition, unknowns, and major life events that can cause much distress in expectant parents and call for psychosocial adjustments (Deave et al., 2008; George et al., 2013). These changes, the complexity of them, and the stigma that befalls those who are experiencing anything other than the “ideal pregnancy” (Public Health Agency of Canada, 2012), predict considerable hindrances to the detection (D. E. Kingston et al., 2015; Kopelman et al., 2008), and treatment of perinatal depression and anxiety (Furtado et al., 2019; D. Kingston et al., 2014). This presents a significant public health concern, associated with morbidity for families (Dunkel Schetter & Tanner, 2012; Fairbrother et al., 2015; Shahhosseini et al., 2015).
Structural and attitudinal barriers to perinatal mental health care access have been explored extensively from women’s perspectives (D. Kingston et al., 2014; Kopelman et al., 2008; Kruper & Wichman, 2017). In 2008, Kopelman et al. found that women are reluctant to trust their PACPs to address concerns about antenatal depression, and fetal medication exposure (medicating their symptoms) (Kopelman et al., 2008). Women hold apprehensions about endangering their parental rights (being viewed as unfit to care for their child/children) (Kopelman et al., 2008) by disclosing mental health concerns to their healthcare providers. Fears of being viewed as a bad mother reduces their willingness to be honest about their concerns with their providers (D. E. Kingston et al., 2015). This elucidates how stigma has a considerable impact on honest discussion and disclosure when addressing mental health during pregnancy (D. E. Kingston et al., 2015). This has important implications on efforts to identify AD in antenatal care. In a 2018 study, Byatt et al. described the value of having providers discuss how mental health concerns can occur during and after pregnancy in helping PP act on any concerns (Byatt et al., 2018). Indeed, PACPs play an integral role in empowering PP through education and the normalization of mood during pregnancy and postpartum. Very few women proactively seek help and less than 15% of women experiencing anxiety or depression receive needed mental healthcare (D. Kingston et al., 2014). Additionally, when experiencing anxiety and/or depression, people are more likely to experience disability, which influences PP’s ability to care for their needs and their likelihood to seek and receive antenatal care (World Health Organization, 2008). Often, these manifest in avoidance of antenatal care (Stewart, 2011), poor adherence to care recommendations (World Health Organization, 2008) and poor health habits relating to sleep and nutrition (Kruper & Wichman, 2017) that exacerbate their condition and risk of poor health outcomes (BC Reproductive Mental Health Program, 2006). Addressing AD
in pregnancy is a key modifiable factor in the vulnerability to short and long-term health concerns.

In 2018, Coburn et al. asserted that to date, there is a dearth of research examining the effects of prenatal depressive symptoms on infant physical health (Coburn et al., 2018). Research indicates that AD can have different effects on the fetus (Reissland et al., 2018). Anxiety has had more demonstrated effects on fetal outcomes, including fetal and birth weight, neurodevelopmental variations, and behavioural and emotional challenges in children (Reissland et al., 2018). Postpartum depression has been associated with poor parent-infant bonding which contributes to adverse child development outcomes such as lower IQ (Azak, 2012), depression and anxiety (Murray et al., 2011), and antisocial behaviours (Hay et al., 2010). When mental health is addressed during pregnancy, the risk of postpartum challenges is minimized.

Ultimately, pregnancy is not protective against mental health challenges. If anything, the life transitions and mood fluctuations associated with them present much stress to PP and have deleterious effects on their MH. The physiological changes that accompany perinatal AD and the healthcare gaps that exist for those experiencing them are likely to increase risk of teratogenic effects on health and development of the child (Coburn et al., 2018). That is to say, they can disturb the development of the baby and have effects that are not restricted to infancy (Coburn et al., 2018), with children exhibiting high levels of anxiety into adulthood (Furtado et al., 2019; Murray et al., 2011). For example, the effects of serotonin system alteration (resulting from antenatal stress) on fetal development can increase risks of psychiatric distress in the child/ren later in life (St-Pierre et al., 2016). This elucidates early social determinants of health (i.e. fetal origins) that are largely avoidable if mental health is addressing with PP in the antenatal period.
Health disparities among marginalized populations, including people of low socioeconomic status (SES) and ethnic minorities, may originate from perinatal exposures (Coburn et al., 2018). In a study with women who gave birth in British Columbia between 2000 – 2009, Hanley et al. (2018), called attention to the role of SES in women’s access to healthcare services for mental health concerns during pregnancy (Hanley et al., 2018). Predictably – given the private nature of mental health care – women of higher SES are more likely to access specialized mental health care than their low SES counterparts (Hanley et al., 2018). This is significant as it illustrates the intergenerational relationships throughout SES, access to care, health inequities and social disparities (Hanley et al., 2018; Richmond, 2019). This cyclical relationship could be interrupted with equitable access to mental health care throughout the lifecourse, including during pregnancy. This would mitigate the short and long-term effects of AD in pregnancy on PP, children, and families alike. Antenatal care presents ample opportunity to identify actual and potential challenges in PP and their infants (Downe et al., 2016). To support PP and promote optimal functioning for their infants, mental health should be a priority in antenatal care.

1.1.2.1 Social Determinant Considerations

Poverty, migration, extreme stress, exposure to violence (domestic, sexual and gender-based), emergency and conflict situations, and low social support generally increase risk of AD during pregnancy (WHO | Maternal mental health, n.d.). Mental health during pregnancy is predominantly undermined or supported by relational, experiential and material factors, including socio-economic deprivation – all impacting PP’s mental health service requirements (Franks et al., 2017) and the costs associated with them. For instance, older mothers are at an increased risk of maternal and perinatal morbidity and mortality (Fairbrother et al., 2015; Misra
With maternal age rising – in 2011 the average age of mothers at childbirth rose to the oldest age on record, 30.2 years (Government of Canada, 2014). High-risk pregnancies contribute to excess health service expenditures (Fairbrother et al., 2015) and with women living well into their 80s, the long-term cost-savings of maternal mental health prevention and management could be substantial (Misra & Grason, 2006).

The antenatal period offers opportunities to address health inequities. However, the psychosocial nature of the stressors associated with AD require the acknowledgement of how social determinants impact people’s likelihood to experience AD in pregnancy, how accessible mental health care is to them, and what their outcomes look like. In this section, I briefly argue: health equity is not attainable without accounting for and addressing these intersecting social factors; when we don’t, we endorse a status quo that perpetuates colonial, cisgender, heterocentric, ableist, white patriarchal supremacy. Although not the focus of my study, it is important to be inclusive in moving toward improving pregnancy mental health outcomes and in being more responsive to the needs of our people. Health equity is an impossibility if we do not recognize how identities shape access to quality healthcare.

Pregnant people (PP) who are members of marginalized groups demonstrate lower access to perinatal care, influenced by the relevance and acceptability of available supports. That’s to say, even when services are accessible and affordable, the needs of people with marginalized identities are still unmet (Downe et al., 2016). To illustrate, Indigenous communities, including First Nations, Inuit and Métis peoples, consistently experience poorer birth outcomes than settler populations (Shah et al., 2011; Smylie et al., 2010). This has been attributed to the intergenerational trauma that affects Indigenous peoples’ physical, mental, emotional, and spiritual wellbeing (Reading & Wien, 2009). Canadian maternal morbidity and mortality
surveillance does not include race, ethnicity, nor culture. This is because national data collection tools like vital statistics and national hospitalization databases do not collect information on ethnicity (including Aboriginal status). This not only leads to underestimations of perinatal morbidity and mortality rates in Canada (Cook et al., 2017), but underrepresents health disparities that exist among our Aboriginal, immigrant, and refugee populations. In the United States, there are persistent racial disparities in perinatal health outcomes – specifically, maternal deaths among Black and Indigenous people. Most are preventable (Jacobo, 2019). Without vital statistics that capture race and ethnicity, we have no way of knowing how Canada compares to the States regarding racial perinatal health disparities. This is a large gap in our knowledge base, that introduces many missed opportunities for health equity.

1.1.2.1.1 Healthcare as a determinant

Research shows that up to 50% of pregnant people (PP) experiencing mental health challenges have unmet psychological needs (Kruper & Wichman, 2017). In Canada, 13% of women report receiving little to no mental health support during pregnancy (Canada, 2016a). Anxiety and depression (AD) in pregnancy has been associated with decreased perinatal care usage, increased unfavourable care habits, and increased risk of substance use (Kruper & Wichman, 2017). When the psychosocial is integrated in perinatal care, PP have been found to be 4 times more likely to engage in care (Kruper & Wichman, 2017).

The pathologization of the embodied experiences associated with advanced age, race, gender, sexuality, and disability is pervasive in healthcare. For example, LGBTQ2SI+ individuals have been found to experience discrimination and prejudice in healthcare settings, resulting in poor health outcomes (Alencar Albuquerque et al., 2016). LGBTQ2SI+ health has a long-standing history of pathologization. Same-sex attractions were considered mental disorders
until 1990 (when they were removed from the WHO’s mental disorders list), and gender diverse/non-conforming identities continue to be medicalized. To this day, the latter has diagnostic criteria in the DSM (American Psychiatric Association, n.d.). Historical context is important as it predicts attitudes and perceptions held today. In LGBTQ2SI+ people, internalized discrimination has been linked to stress-related cortisol production that result in anxiety, depression, and suicidality. Healthcare is by no means a vacuum, free of violence and discrimination (Canadian Mental Health Association, n.d.). Social determinants and healthcare have a cyclical relationship whereby social factors impact healthcare access and service usage, while healthcare accessibility has social impact. It is evident that healthcare is a structural determinant of health. To care for our populations equitably, we must recognize how the erasure of complexity in people’s experiences (and embodiment of them) lends itself to ongoing health and social inequities. The assumption that pregnant people are necessarily able-bodied, neurotypical, cisgender females in heterosexual relationships is dangerous.

The Ministry of Health released policy papers focused on key healthcare priorities in 2014, including Primary and Community Care in BC: a Strategic Policy Framework (updated: February, 2015) in which patient-centered, integrated primary and community care were stated priorities as “health care is about providing care to fellow human beings” (Ministry of Health, 2015). To minimize health disparities, it is essential to recognize how social identities shape experiences with healthcare and how the system and the services it provides can provide them with dignity and respect (as opposed to prejudice, discrimination, and neglect).

1.2 Knowledge-to-action: transformational intent

Historically, population health research has endeavoured to influence policy, practice, and action in a linear fashion from evidence to implementation, from knowledge producer to
knowledge user. However, this deferral of responsibility (from producer to user) has resulted in gaps in implementation and responsiveness to health disparities. As noted by Straus (2009): “Knowledge creation (i.e., primary research), knowledge distillation (i.e., the creation of systematic reviews and guidelines) and knowledge dissemination (i.e., appearances in journals and presentations) are not enough on their own to ensure the use of knowledge in decision-making.” (S. E. Straus et al., 2009) In some cases, it takes up to 17 years to implement evidence-based recommendations (Morris et al., 2011). Consequently, there has been a call to engage knowledge producers and users collaboratively in the development of knowledge translation (KT) to not only ensure action, but sustainability. This means having relevant stakeholders involved in the research from the outset, establishing KT as a priority in health research (rather than an after-thought).

Knowledge Translation (KT) is defined by the Canadian Institutes for Health Research (CIHR) as a means through which to raise knowledge users' awareness of research findings and facilitate the use of those findings (Canadian Institute of Health Research, n.d.-a). It is a dynamic, comprehensive process that creates and converts knowledge into actionable packages to inform efficient changes in quality of care, practice, and systems priority-setting (Khoddam et al., 2014). It involves knowledge synthesis, dissemination and ethically sound application of findings “to improve the health of Canadians, provide more effective health services and products and strengthen the health care system.”(Canadian Institute of Health Research, n.d.-b).

I define Knowledge-to-action, for the purpose of this thesis, as the strategies developed to move beyond KT and dissemination toward implementation (i.e. actions toward change/s). Traditional top-down primary care practice and the linear development and dissemination of KT (from knowledge producer to user) have been associated with gaps in implementation and issues
with sustainability (Davies & Edwards, 2009). This is due to determinants of knowledge use (e.g. relevance) and the complexity of knowledge use contexts (e.g. professional demands) (E. Straus et al., 2009). Indeed, when stakeholders (and their needs) are left out of KT, strategies do not account for (i.e. maintain) routinized paternalistic patient-provider relationships (power hierarchy) wherein patient values and preferences are not factored into care planning, leading to unequal burdens (or benefits) to one group relative to the other (i.e. provider versus patient) (Davies & Edwards, 2009). This leads to unrealistic goal setting, low trust between providers and patients, and decreased effectiveness of treatment and management (Brouwers et al., 2009). Poor management results in more complications and the need for more specialized, costly care. This strains individuals, PACPs, and our healthcare system. With growing appreciation for the deleterious effects of undetected anxiety and/or depression during pregnancy, it is important to close the gap between what is known and what is being done.

The goal of this project has been to garner a deeper understanding of the challenges and complexities in addressing anxiety and depression during pregnancy from PACP perspectives. As the main and most constant point of contact with the healthcare system, PACPs are instrumental in improving perinatal health outcomes. Their perspectives offer important insights to how our systems can better support perinatal health outcomes.

At the outset of this investigation, I intended to pursue the development of a KTA strategy tailored to PACPs as I perceived them to have the responsibility to lighten the load for PP. An understanding of end-user attitudes and perspectives is important to inform KTA strategy development, to account for determinants of usage. My end-of-study KTA goal was to establish a strategy that would identify and engage its users (PACPs), promote the value of identifying and supporting cases of AD during pregnancy to them, and provide stakeholders the opportunity to
engage in the development, delivery and refinement of the resultant strategy. Currently, much of the knowledge translation pertaining to perinatal health is targeted toward the patient population as disclosure and self-management recommendations). However, as previously stated, PP experiencing AD are unlikely to disclose concerns, and often avoid antenatal care; power hierarchies in healthcare relationships go unaddressed, over-burdening PP with the responsibility to identify and manage their mental health concerns.

After discussions with my Supervisory Committee, and in light of the Results of this study, we decided to focus on my primary objective to investigate PACP attitudes and perspectives pertaining to: (a) anxiety and depression during pregnancy; (b) barriers and facilitators to identifying and supporting pregnant people experiencing anxiety and/or depression during pregnancy; (c) knowledge needs to address anxiety and/or depression during pregnancy.

In lieu of a KTA strategy, recommendations are made based on participant-identified priorities. Namely drawing from their reflections on our healthcare system’s responsibility to integrate mental health. At present, this has been deferred to PP and PACPs. Both reporting experiences of feeling overburdened (and stressed); they can only do as much as the system allows. Based on participants’ descriptions of their professional demands, I call on health care education, provision, research and priority-setting (i.e. funding, from local to Federal levels) – as significant determinants of health – for action.
Chapter 2: Methodology

This qualitative study explored the attitudes and perspectives of primary antenatal care providers (PACPs) addressing anxiety and depression (AD) during pregnancy. I used Interpretative Descriptive methods to analyze and report on participants’ perspectives regarding how PACPs in Greater Vancouver, British Columbia currently address AD in pregnancy, and what is needed to better support them in doing so. I asked:

What are PACP’s attitudes and perspectives regarding anxiety and depression during pregnancy, those who experience it, and how to address it? Specifically,

- What do PACPs consider barriers/facilitators to addressing anxiety and depression with pregnant people?
- What are the barriers/facilitators to knowledge implementation in their care contexts?

The former focuses on current practices while the latter focuses on considerations for new practices (and knowledge-to-action strategies). These exploratory questions were formulated to inform gaps in knowledge regarding the phenomena of interest: addressing AD in antenatal care (from identification to management). I perceived PACPs to be in the unique position to leverage their knowledge and skills to shape care and impact health outcomes at every level of care provision: from individual to system. Taking into consideration the continuous nature of perinatal care, and the ample opportunity to detect and provide support for AD therein, I identified PACPs as the population of interest. Thus, understanding how to incentivize and support PACPs in catalyzing change was a priority. This was corroborated with existing evidence on the integral role of PACPs to increase detection and treatment of anxious/depressive symptoms (Kim et al., 2009; Price et al., 2012).
In the tradition of qualitative research, I have reflected on my positionality as a childless graduate student feminist without perinatal care training and these identities’ roles in constructing the knowledge shared herein. Participant data are subjective, as they have shared their personal clinical experiences with AD during pregnancy. My interpretation of their reflections is inherently subjective and as the research instrument, one of the ways to build in accountability to this research was to reflect on the assumptions and biases I carried throughout. With rigorous analysis, reflexivity (memo-writing), and member-checking combined, the results are defensible and trustworthy (established in 2.4). The knowledge gained from one-on-one interviews with PACPs offers significant lessons for care delivery, priority setting (e.g. funding), and health outcomes.

The following describes the interview process from the creation/development of the interview guide, through recruitment of participants, to data collection and data analyses.

2.1 One-on-one Interviews with Primary Antenatal Care Providers

Knowledge was co-produced via one-on-one semi-structured interviews with primary antenatal care providers (PACPs). The recruitment aim was a purposive sample of fifteen PACPs including five obstetrician-gynecologists (ObGyns), Family Physicians (FPs), and Registered Midwives (RMs). In total, twelve PACPs were interviewed (n=12), including three ObGyns, five FPs, and four RMs. I conducted all interviews, audiotaped with consent, and transcribed them verbatim for analysis. All participants signed an informed consent form (Appendix B) that detailed the terms of informed consent (respect and welfare), confidentiality (respect and welfare), and consequences (harm; welfare) in participating.

A semi-structured interviewing approach was undertaken as it enables reciprocity between interviewer and participant, and allows space for both to explore topics deeply without
the rigidity of following a predetermined structure strictly (Kallio et al., 2016). This interview approach has been found useful in obtaining descriptions of different attitudes and perspectives on complex issues and allowing for diverse expressions as participants have the space to dive deeply into the issues most meaningful to them (Kallio et al., 2016). This interviewing style was guided by a sequence of themes (i.e. anxiety and depression during pregnancy; barriers/facilitators; knowledge needs), some suggested questions, as well as a case study vignette to spur conversation around how the interviewee would approach the situation presented. The vignette was borrowed and modified from Marnes, J. & Hall, P. (2013) to depict a woman exhibiting signs of depression during her third trimester (Appendix C). Altogether, I selected this method of knowledge production in the interest of establishing a conversational relationship with participants, encouraging nuanced and rich descriptions from them, and co-constructing meaning together (Brinkman & Kvale, 2015).

PACPs self-selected into the study and were not offered incentivization (i.e. a gift, monetary or otherwise). It was anticipated that participants would have interests in promoting perinatal mental health awareness among their patients and peers. They were asked questions to gauge the best strategies to engage and incentivize PACPs to: (a) start and sustain mental health identification, promotion, and management conversations with PP; (b) set person-centered care as a priority. Further, the interviews aimed to garner an understanding of different provider group challenges to mobilizing existing knowledge and resources toward supporting PP experiencing anxiety and/or depression during pregnancy. Cumulatively, the questions asked were designed and tailored to receive rich descriptions of how participants view themselves and their roles within the phenomena, and what their needs are in addressing pregnancy-specific AD.
2.1.1 Developing the Interview Guide

A semi-structured approach to interviewing was taken in the interest of allowing space for the co-construction of knowledge between the interviewer (myself) and interviewee. The questions were designed to prompt descriptive responses from participants whereby they would reflect on their experiences addressing AD in the antenatal period and their knowledge needs to do so. Given that three different provider groups were interviewed, I found this design favourable as it supported nuanced descriptions of experiences with the phenomenon subject to investigation. The use of “what”-based questions (Appendix D) elucidated PACPs’ relationships with addressing AD in the antenatal period as FPs, RMs, and ObGyns providing care in Greater Vancouver. All questions were informed by my critical appraisal of the knowledge base regarding the identification and management of AD during pregnancy (Kallio et al., 2016). The guide was revised and approved by my co-Supervisors; one an expert in qualitative methods, the other an expert in perinatal mental health research.

The interview guide was designed to gently guide participants through a progressive dialogue that began with current practices addressing AD during pregnancy with PP and culminated in reflections on knowledge implementation needs in their care contexts (to support PACPs in addressing AD). To begin, two introductory questions were posed: (1) “Tell me a little bit about yourself, how long you’ve been a Primary Antenatal Care Provider, and what drew you to this line of work?”; (2) “Could you set the scene for a typical day on the job for you?” This allowed us to settle into the interview, while also spurring rich descriptions about the contexts and circumstances they were approaching our time together from and investigation with (Brinkman & Kvale, 2015; Kallio et al., 2016).
To elucidate PACPs’ approaches to the identification and management of AD during pregnancy, a case study was modified from Marnes, J. & Hall, P. (2013). “Midwifery care: A perinatal mental health case scenario” (Appendix C). Specifically, it was edited to portray its subject, Jen, as being in her third trimester instead of postpartum. In its original form, this semi-fictional case study was used by Marnes & Hall to inform recommendations for implementation in midwifery practice “consistent with the National Perinatal Depression Initiative” in Australia (Marnes & Hall, 2013).

Interviewees were encouraged to keep the case study vignette as I asked them to “walk me through how you would approach the following situation” and followed up with probing questions such as why they would be concerned for Jen (i.e. what was concerning) and what their next steps would be. The case study also referenced two screening measures. One was the Edinburgh Postnatal Depression Scale (EDPS). In 2006, Perinatal Services BC recommended the EDPS to PACPs to screen for AD with PP (BC Reproductive Mental Health Program, 2006). Since then, it has been embedded in their antenatal care forms to be administered at 28 – 32 weeks gestation. So, I asked participants about their familiarity with and use of this tool. The case study vignette ensured I could triangulate responses across participants (three provider groups), an approach whereby the same event is described from the perspective of more than one participant (Sandelowski, 2000). Indeed, case study vignettes have been found to be useful in stimulating revelatory reflections imbued with contextual values (Spalding & Phillips, 2007).

The interview had two main sections: one focused on current practices, the other on knowledge implementation needs. The last questions were intended to inform knowledge-to-action (KTA) and thus had transformative goals. Insights to PACP perceptions of “common reasons evidence-based knowledge doesn’t get implemented in care settings” and “what would
be essential to ensure the uptake of a new care strategy/approach” aimed to stimulate reflections on new possibilities for action (Brinkman & Kvale, 2015).

There was no pilot testing of the interview guide. Once my Supervisory Committee and UBC BREB accepted the guide, no edits were made to it throughout the study save the informal correction (i.e. not reflected in the guide) of language from binary to gender neutral, including “maternal” to “perinatal” and “women” to “people”.

All questions were designed to be short, open-ended, and provide space for me to follow-up with clarifying questions. From the beginning (introductory questions), to the end (need-based questions), the structure of the interview lent itself to rapport and trust building. Cumulatively, the design was conducive to spontaneous and rich answers.

2.2 Participant Engagement

A purposive sample of three PACP care provider groups (RM; FPs; ObGyns) who provide antenatal care within the Greater Vancouver Area were recruited. In BC, PP are able to choose to be cared for by a registered midwife (RM), family physician (FP), and/or obstetrician-gynecologist (ObGyn) throughout the perinatal period (HealthyFamiliesBC, n.d.). Thus, for inclusion, participants had to be a PACP delivering antenatal care within Greater Vancouver and speak English fluently. There was no exclusion of participants based on years of experience. This non-probabilistic sampling approach was selected to represent in-depth, contextual accounts of priorities, interests, and dynamics in the three areas of antenatal primary care provision (Berg & Lune, 2017).

2.2.1 Recruitment Methods

The recruitment goal of this study was five participants from each provider group (i.e. purposive sample). Recruitment began after UBC BREB approval (granted August 28th, 2017),
in September 2017, and ended in July 2018. The participants of this study were self-selected PACPs delivering antenatal care in Greater Vancouver.

To recruit a purposive sample of PACPs from the three areas of antenatal care provision, recruitment was attempted through various means: (1) publicly available email, telephone, and fax, (2) professional listservs and newsletters, (3) presentations, (4) recruitment cards. No incentive was offered to participants, which limited responsiveness to recruitment. An email of initial contact (Appendix E) was distributed to clinics providing prenatal care with a basic overview of the study. It included a short description of the study, its objectives, and an “ask” to be invited to give an in-person presentation of the research opportunity. The Midwives Association of BC, BC Midwifery Network, BC Women’s Hospital and their recommended partners (as listed on www.bcwomens.ca “Find a Maternal Care Provider”) were contacted, among others.

When the response rate proved to be low, I decided to contact individual PACPs through publicly available contact information. Initially, emails and telephone calls were the main pathways for recruitment efforts. However, after experiencing poor responsiveness, I considered different approaches. My recruitment email was shared through listservs and newsletters, such as: BC Midwifery Network listserv, Division of Family Practice newsletter, and BC Women’s Hospital + Health Centre ObGyn Rounds Newsletter. Eventually, a participant recommended I send my recruitment email via fax to providers. According to her, care providers must go through their faxes, whereas email and telephone calls are often screened by assistants. To supplement my efforts, I went in-person to local clinics with recruitment cards to leave with administrative staff and contacted departments and local clinics to give short recruitment presentations and leave recruitment cards. The in-person presentation was 4 slides long,
including an introduction to the study, its significance, PACPs' roles, and researcher contact information (Appendix F). Recruitment cards’ study information included the study's name and purpose, inclusion criteria, and contact information (Appendix G). Very few presentation opportunities were offered. I eventually tried a snowball sampling approach whereby I asked participants at the end of our time together whether they would share my recruitment email with their colleagues. However, this proved fruitless; none of the participants included in this study had been referred by a colleague I had interviewed.

Irrespective of the pathway for first contact, I followed-up on replies, screened participants, provided them my informed consent form to familiarize themselves with the study, answered questions as necessary, and set appointments for interviews. All participants provided consent to be interviewed, understanding their data would be anonymized and stored up to five years in a secure location (per UBC BREB).

Of all PACPs, FPs were the most responsive (n = 5) and ObGyns were the most difficult to reach (n = 3). So much so, I travelled to Victoria to attend a day of the Society of Obstetrics & Gynecology of Canada Conference thinking they would already be taking time out of their regular schedules for this weekend event and be more willing to participate. While there, I interviewed one ObGyn. Following the advice of my supervisory committee, recruitment finished in July 2018. I had interviewed 5 FPs, 4 RMs, and 3 ObGyns (n=12).

2.3 Interview Analysis

The data co-produced through interviews was analysed inductively. Given the exploratory nature of the project, I employed an inductive approach to identifying observable patterns throughout and within PACP interview data. From codes to themes, the generalizing statements made in the Results grew from specific observations, tracked via memos, and
corroborated through member checking. All data analysis was done by hand (i.e. not computer-assisted). I favoured this hands-on approach over the suggested patterns generated by software-assisted means as it supported my familiarity with the data and deepened my engagement with the themes. In this way, I maintained greater control over the data analysis process and felt intimately involved in the co-creation of the Results discussed herein.

2.3.1 Coding

The qualitative analysis of transcripts was first approached using a fundamental descriptive qualitative method. The idea being that it would lend itself well to elucidating descriptive summaries of participants’ perspectives (Sandelowki, 2000) in ways that would best represent and consider their day-to-day practice realities. As I moved through coding and interpretation, working my way toward concepts, writing memos to keep track of and cross-reference observations made within and throughout transcripts, I started clarifying themes (Sally Thorne, 2008). Memos detailed codes’ definitions (i.e. related meanings) and relationships as well as example quotes. Initially, I undertook open coding (Babbie & Benaquisto, 2002), contrasting and comparing every new happening revealed. Each transcript I read brought clarity or new language to existing codes or surfaced new ones. I began to write recurring codes on post-it notes and once exhausted, I tried to cluster them based on their relationships to one another. I then revisited transcripts and memos to focus my coding toward identifying overarching ideas. Increasingly, observations of participants’ accounts of their relationships with the phenomena crystalized and I collapsed codes into categories. Still, I funneled the code names into the categories’ descriptions for reference and nuance. All categories included definitions, codes, and examples for explicitness. Then, I began to think about the distinctiveness, intersections, and interrelatedness of individual, dyadic (PP-PACP), systems, and social factors
in the phenomena discussed (addressing AD during pregnancy and knowledge implementation in perinatal care settings). Eventually, I took a stab at writing my results. This applied practice of thinking through the codes, categories, and themes translated to another level of analysis whereby I found I had restricted my thinking in some regards; I was continuously confronted with how this approach was misaligned with my critical constructivist lens.

Upon reflection, I found I was reporting on the data in a withdrawn manner that minimized the richness of the data participants and I had co-constructed in the time we spent together. In my efforts to write a fundamental description, my reporting was devoid of how the complexities – and the implications of them – were experienced by participants. I felt I had done a disservice to the space we’d shared and the interpersonal meaning-making we’d created within it. Then, I reminded myself of Sally Thorne’s “Interpretive Description” (2008). Again, reflexivity is important. In Interpretive Description, the reflective reasoning process shapes how one approaches their search for meanings regarding what is happening (culture of perinatal care) and nurtures deeper understandings of what the optimal responses would be (in perinatal healthcare). Ultimately, I reflected on how the participants were my guides throughout and my role in portraying their realities fairly (i.e. in ways that positioned them as the experts of their own experiences and needs). Steeped in my results, I undertook a suggested narrative exercise in which I wrote out the key take-aways from my analysis in a stream of consciousness (Appendix H). A cultural world of which the interviews are a specimen revealed itself (Perakyla, 2005). That’s to say, the participants’ experiences, attitudes and perspectives invited me into the cultural world of perinatal care – a place within and at the intersections of our social, healthcare, and government structures. From there, I began to build the results I share with you now. The themes (and sub-themes) discussed herein were developed in the culmination of these approaches;
reconciling my first draft with the new insights the Interpretive Description narrative exercise elucidated.

2.3.2 Interpretive Description

Interpretive description, to paraphrase Sally Thorne (2008), is a methodology that arose from a need for qualitative research to garner in-depth understandings of complex phenomena of concern to applied disciplines within health (Sally Thorne, 2008). This conceptual frame serves as a guide toward building a solid and defensible body of knowledge upon which to decide whether the results are worthy of serious attention (Sally Thorne, 2008).

In population health investigations, qualitative research methodologies have been borrowed from social sciences including anthropology, sociology and psychology. Respectively, ethnography, grounded theory, and phenomenology lay the foundation for the approaches used today (Sally Thorne, 2008). In 1997, Thorne, Reimer Kirkham, and MacDonald-Emes presented Interpretive Description (ID) as a means to move beyond these methodologic traditions and be more “responsive to the experience-based questions of interest to a practice-based discipline” (S Thorne et al., 2004). While each of its preceding methodologies play roles in making sense of the world and its ideas, ID was created to meet the pragmatic demands of applied disciplines in healthcare (Sally Thorne, 2008). I gravitated toward ID as it lends itself well to deconstructing what existing knowledge has been founded on and uncovering new insights to apply to practice, moving beyond description and driving the implications of the research toward application (Sally Thorne, 2008).

Like traditional qualitative descriptive approaches, ID uses inductive analytic approaches to explore phenomena. However, it reaches beyond descriptive approaches to yield meanings and explanations with practice implications. Samples are either purposively or theoretically
generated to reflect expected and emerging variations in perspectives. Throughout the analytic process, data management, reporting coherence and rigor are essential to the potential implications of the knowledge generated. In this way, ID provides a coherent structure and orientation toward practice-relevant knowledge with attention to disciplinary biases and commitments (purposive sample) (Hunt, 2009). While limitations to ID exist, such as it being a lesser-known methodology and uncertainties associated with such (Hunt, 2009), they ultimately lend themselves to the researcher building in and reporting on quality criteria and systems of accountability to the work that convince readers of the results’ significance. In this section, I provide the logic that justifies the methodologic decisions, techniques and procedures used in my ID of PACP experiences addressing AD with PP and their alignment with my research purpose: to understand current practices, and broaden understandings of what we do and don’t know on the basis of existent evidence. True to ID, my thesis guides readers through a complex reality wherein addressing AD during pregnancy is the case study and PACPs are the sample. I present examples of patterns that account for individual perspectives while illustrating thematic patterns that characterize the clinical phenomenon of interest with intended application potential (Sally Thorne, 2008). The results herein provide a rich contextual account of current practices in the identification and management of AD during pregnancy (including barriers and facilitators to both), extending available knowledge for decision-making and clinical reasoning with real world healthcare applications. My work offers practice disciplines in perinatal healthcare extended understandings of perinatal mental health management and identifies opportunities for assessment, priority-setting, and interventions.

With ID in hand, I set out to explore the clinical phenomena of addressing AD during pregnancy within the larger context of the culture of perinatal care. With all the intersecting
complexities in the identification and management of AD in pregnancy, exploring PACP perspectives offers new ways of viewing these phenomena and how to address them in clinical settings. I found this approach supported me in leaning into the complexity and in framing the reporting of such in a nuanced analysis with significant implications from practice to policy.

Although we can speculate that all PACPs have a vested interest in perinatal health outcomes, each provider group operates under different mandates and have disparate professional interests. I considered Interpretive Description well-suited as an integral part of this approach in transmitting the value of all expressed perceptions. This methodology is inherently phenomenological, which insists on the important reality being the one that participants perceive as such (Brinkman & Kvale, 2015). The thematic and integrative description of PACPs’ perceptions captures individual and collective contributions to the findings, honouring nuance and complexity of experiences, while identifying overarching patterns in how AD is addressed by participants and opportunities to improve perinatal care (for PACPs and PP alike).

The results describe what was observed in the data throughout analysis and reporting. Participants spoke to the “what”, “how”, and “why” of the barriers and facilitators to addressing AD and knowledge implementation in their care contexts. The descriptive themes detailed in the Results, were developed directly from language used by participants. All terms used are commonplace and have known definitions, all relating to care delivery in antenatal settings.

2.3.3 Knowledge-to-action

I consider myself a community-based activist and advocate for reproductive justice. As such, I have vested interests in the role of research in catalyzing change and subverting the status quo. Thus, I have carried the curiosities associated with knowledge-to-action (KTA) throughout this work. At the outset, given my assumptions about PACPs, I conceptualized this investigation
as necessary to inform KTA. I thought: the evidence-base is full of how and why AD must be addressed during pregnancy; how do we get PACPs to mobilize it toward improved health outcomes and mental health integration in their clinical settings? I assumed the reason why they weren’t was because of the linear dissemination of knowledge and issues with relevance and implementation. Historically, population health research has endeavoured to influence policy, practice, and action in a linear fashion from production to implementation; from knowledge producer to knowledge user. However, this deferral of responsibility has resulted in gaps in implementation and responsiveness to health disparities. In some cases, it takes up to 17 years to implement evidence-based recommendations (Morris et al., 2011). Consequently, there has been a call to engage knowledge producers and users collaboratively in the development of KTA to not only ensure action, but sustainability. This means having relevant stakeholders involved in the research from the outset, establishing KT and KTA as a priority in health research (rather than an after-thought). Hence, I pursued interviews with PACPs as a means to integrate their realities and needs in producing new knowledge with implications for their practices, and KTA. However, although the former is presented in this write-up, the latter was considered beyond the scope of a Master’s Thesis (in conversation with my Committee).

PACPs are on the frontlines of antenatal care provision and their knowledge and skills can be leveraged to generate change and improve perinatal health outcomes in BC. With growing appreciation for the deleterious effects of undetected AD during pregnancy, it is important to close the gap between what is known and what is being done. The Interpretive Description undertaken here offers insights to this. The knowledge produced throughout this project informed recommendations (presented in Discussion) that cultivate awareness of how the
participants perceive their role in addressing AD during pregnancy and create demand for supports to address AD during pregnancy for PACPs and PP alike.

2.4 Trustworthiness

Generalizability has connotations of being neutral and impartial (Carminati, 2018). Its alignment with positivist supremacy makes it challenging for social constructivist researchers using interpretive qualitative methods like myself to argue how findings can be appropriately generalized. Indeed, transposing the concept of generalizability onto research that explores personal perspectives, constructs concepts in relationships with participants, and reports rich descriptions of human experiences has been dismissed by many as a necessity in determining the quality of qualitative interpretations (Carminati, 2018; Harrison et al., 2001). For decades qualitative researchers have been negotiating alternative requirements to assert the trustworthiness of their work. Some that have been particularly well received within the qualitative health research community are those articulated by Leininger (1994), who conceptualized the six distinct evaluative criteria that should be considered as credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability (Sally Thorne, 2008). The requirements for “trustworthiness” used by Lincoln and Guba to position a study as “worth paying attention to” include: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). In 2018 Carminati argued that for interpretive research to be trustworthy and its results to be appropriate and relevant to the general population of interest, it is up to the researcher to thoroughly and exhaustively establish them as such (Carminati, 2018). Here, I take you through considerations for the trustworthiness, relevance, appropriateness, and dependability of this study. Ultimately, I establish them relative to the concepts (i.e. themes) that make sense of how PACPs address AD during pregnancy and what
their knowledge needs are to support them in doing so, without limiting context nor populations. Participants included PACPs from the three groups PP can choose to be cared for throughout pregnancy in BC. Further, each of them emphasized the diversity of the PP populations they serve. Correspondingly, the results demonstrate much complexity and showcase the diversity of needs in perinatal care (PP and PACPs alike). Thus, generalizability is not the aim; rather, relevance was a marked priority among participants.

Firstly, it is worth revisiting my research objectives, as they shaped the undertaking of this research. For instance, I chose to pursue data collection via interviews given their promise for producing knowledge that can contribute to new understandings of PACPs’ contexts, and to affecting change within them (Brinkman & Kvale, 2015). To garner a deeper understanding of how PACPs identify and support PP experiencing AD, as well as explore ways to better support PACPs in doing so, I asked about their attitudes and perspectives toward: (a) anxiety and depression during pregnancy; (b) barriers and facilitators to identifying and supporting (i.e. screening, referral, management) PP experiencing anxiety and/or depression during pregnancy; (c) determinants of knowledge implementation in perinatal care settings.

Again, I formulated these goals operating on the assumption that PACPs had the power to transform perinatal care outcomes and practices. I pursued these goals with Interpretive Description as I perceived it to align with producing knowledge that would have healthcare implications, expanding on what is known (evidence-base), offering something new, and options for action (KTA aims). Given the transformative goal of this research, the results are meant to be appropriate for action and relevant to PACPs in our local systems while maintaining flexibility in their relevance to all three PACP groups in BC. The value of qualitative research is that it illustrates the breadth and nuance of people’s experiences with and within the phenomena under
study (Lewis, 2014). The results discussed herein demonstrate the complexity of PACPs’ experiences as individuals, a collective, partners with their clients, and agents within a system.

Specific techniques have been used in the undertaking of this work that have buttressed the trustworthiness of this study. For instance, the use of a case study vignette, diligent reflexive memo-writing, and participant “member checking” reinforced the thematic analysis of transcripts and interpretive description reported on, and built in a system of accountability to the phenomena, participants, myself, and this study.

Throughout the exploratory journey of this study’s design, knowledge construction, and write-up, memo-writing was essential to maintaining the continuity of my thoughts and supporting the quality of their conclusions (Birks et al., 2008). Memos served as metaphorical trail markers as I explored the meanings of participants’ reflections, gauging how far I’d gone, where I’d been, and suggesting where I could go. In this way, memo-writing facilitated the continuity of my interpretations and momentum of my analyses (Birks et al., 2008). Further, memo-writing was useful in triangulating the three participant groups’ realities, as well as served in the triangulation of data sources (i.e. transcripts, memos, and write-up). The triangulation of findings is often used to establish dependability and confirmability (Green & Thorogood, 2010; Sally Thorne, 2008), or in other words, the relevance and trustworthiness of results. The reflexive practice of memo writing was used throughout the research process to document thought and analysis processes, account for biases, and establish trustworthiness. Quality of the research process and results was a continual process (Brinkman & Kvale, 2015), undertaken in the research and reporting process. The iterative nature of qualitative analysis lends itself to rigor throughout the project.
In the interest of maintaining the reciprocity in my relationships with participants, I undertook member-checking. In recognition of how I do not know better that the participants (as the experts of their own experiences and knowledge needs), I wanted to ensure participants felt seen, heard, respected and their perspectives elevated in this write-up. By doing so, I mitigated power imbalances inherent in the researcher-researched dyad and endorsed their authority in the knowledge produced (Harrison et al., 2001). As the investigator, interviewer, analytical instrument, and author of this study, I consider myself to hold much power in the outcomes of this work. Without supporting participants’ power in determining the integrity and quality of this work, I would consider this dynamic exploitative and extractive. That’s to say, holding myself as the researcher and them at the researched “other” would inevitably be a disservice to the participants’ invaluable role in constructing the new knowledge presented herein with me. In effect, I view myself as obligated to honour the relationships created in our time together and the participants’ ownership of their reflections.

I engaged participants in member-checking once my results were written. Instead of sending participants their full interview transcripts (averaging between 12-20 pages), I sent them a personalized document that outlined my results with the excerpts that contained their quotes as elucidatory examples embedded within it. This way, participants received as much context as possible for how their words were being used. All participants were asked to verify my interpretations were true to their intentions and to edit as they saw fit. In the emails, I reminded them of where and when we met, the title of the investigation, and explained:

“I am contacting you as I have written my results and would like you to have ownership over your words. Attached you will find a document I have created with excerpts from my
Only one participant requested the full interview transcript to confirm her quotes. Ultimately, she provided minimal edits. Most replied with little corrections and encouragement. Of the participants (n=12), I was able to member-check all but one. The majority approved their document, and a few requested the deletion of “um”, “like”, and other pausing remarks. Generally, the meaning, interpretation, and significance of their quotes were unchanged. This not only demonstrates the trustworthiness of the interpretive description undertaken, but also builds in a system of accountability to participants as the owners of the experiences they shared. I favoured this means of member-checking for two reasons: PACPs are busy and reading the full transcripts would have been an onerous task; I wanted participants to have ownership over how they were being represented. I view this as an honouring and continuation of our reciprocal relationship. As the insiders to these phenomena, I consider the knowledge herein to be produced in conversation with the participants’ understandings and perceptions (Birt et al., 2016). I reject the use of member-checking for research validity and rigor as prescribed by positivist supremacy and assert my interpretations as trustworthy and just. In this way, I maintain the connections between my values, integrity as an academic, and the implications of this research on reproductive health outcomes (Harrison et al., 2001).

From the outset, my research goals were imbued with the intention to empower PACPs in addressing AD in perinatal settings. This was derived from my critical appraisal of what’s been done (evidence-base) and what I perceived as a viable route to investigate what is necessary for AD to be addressed during pregnancy (minimize adverse health outcomes and establish reproductive health equity and justice). Given the transformative aim and heterogeneity of the
participant groups, this project aimed to be transferable from the outset. That said, the assumptions I held when designing this study have been significantly challenged by the knowledge co-produced with participants. Consequently, although I have carried the value of mental health integration in perinatal care to alleviate the burden of poor outcomes on PP, families, PACPs, organizations, and systems throughout, I have come to understand that placing the responsibility of addressing AD during pregnancy on PACPs would be counter-productive. I entered this work with the perception that PP needs required elevating. Now I see that PACPs’ needs must be met in the interest of the former. That’s to say, I find my sense of moral responsibility has expanded from being PP outcomes specific to include supporting PACPs’ integral role in shaping the former. In other words, to be accountable to PP’s and families’ health and social outcomes, we must invest in supporting providers addressing AD during pregnancy within a system that has yet to integrate mental health. These real life, contextual accounts can guide decisions being made at every level of the phenomena (i.e. individual, PP-PACP dyad, systems, and structural levels). Transferability is sound as three PACP group perspectives have been investigated – all of which have disparate professional practices, training, and requirements. Throughout the investigation of PACP perspectives, power dynamics and competing interests have been considered.

I have provided a detailed account of my interpretive quality measures, including memo-writing and member-checking, to convince you (the reader) of the trustworthiness and credibility of knowledge claims made in the following sections (results; discussion).

2.5 Ethical Considerations

This project was granted approval by the University of British Columbia Behavioural Ethics Review Board, under application H17-01672.
There were no potential risks for PACPs participating in interviews as the subject matter did not depart from the realities of their day-to-day lives as primary care providers to people during pregnancy. Informed consent was obtained from all participants in advance of their interviews (Appendix B). They were informed that they could withdraw from the study at any point without repercussions up to one month after data collection (the interviews) had taken place. All personal/identifying information has been kept strictly confidential with files being stored in the Midwifery Program on the University of British Columbia campus. Hard copy information (such as the consent forms) are kept in a locked filing cabinet while all electronic files (such as interview recordings) are on a secure, encrypted server.

Interviews were recorded using a digital audio recorder. The digital audio files were uploaded and stored on a password-protected full-disk encrypted computer in the Midwifery Program offices at the University of British Columbia. All identifying information, and interview data were stored here as well. All hardcopy documents, such as Consent Forms, were kept in a locked filing cabinet in the Midwifery Program. All audio files were transcribed by me, and the resultant documents were stored on the encrypted computer in the Midwifery Program. After anonymization (exclusion of identifying information), I printed transcripts to perform analysis by hand. All participants received a numerical pseudonym to protect their identity. The participants’ names do not appear on any study documents, other than the consent form and a list of participants' names with their corresponding numerical pseudonyms. This list is kept in a separate locked filing cabinet in Midwifery so as to protect the identity of participants. It will be destroyed upon completion of the project.
All interviews were transcribed verbatim and quality-checked by me. Verbatim transcription was selected to maximize loyalty to participants’ oral statements (Brinkman & Kvale, 2015).

The potential benefits of participating in this research study included co-producing the knowledge described in this write-up and the recommendations made to improve current models/approaches to care. This may encourage participants to demand existing structures to change in favour of engaging PP in their mental health for improved perinatal health outcomes. Further, the inventory of resources included in Appendix J can support their capacity to address AD during pregnancy. This may shift their perspective from being disillusioned with the paucity of knowledge and resources to manage pregnancy-specific AD, to hopeful and equipped to tackle this pressing healthcare issue head-on.
Chapter 3: Results

This chapter presents the Interpretive Description of findings from semi-structured interviews with twelve Primary Antenatal Care Providers (PACPs) actively delivering antenatal care within Greater Vancouver, British Columbia (BC). In BC, pregnant people (PP) are able to choose to be followed throughout the perinatal period (from pre/conception to postpartum) by a Family Physician (FP), Obstetrician-Gynecologist (ObGyn), and/or Registered Midwife (RM). Although Perinatal Services BC has taken measures to address anxiety and depression (AD) during pregnancy, including embedding the Edinburg Postnatal Depression Scale in their antenatal care forms, little is known regarding this persistent health issue from those on the frontlines of care. This study provides descriptions of PACP perspectives in a local context with the aim to understand the barriers and facilitators they face in identifying and managing cases of anxiety and/or depression during pregnancy, as well as their knowledge needs in doing so.

3.1 Introducing the Participants

Twelve participants were recruited from October 2017 – July 2018. Of the twelve, five were FPs, four were RMs, and three were ObGyns. Participants within and throughout PACP sub-groups (i.e. FPs, RMs, ObGyns) presented much diversity in years of practice, the populations they serve, and their day-to-day roles/responsibilities. Participants reflected the status quo of perinatal care providers: all were women, and all but one were white-presenting. All three groups had at least one participant who was a recent graduate at the time of interviewing. The most senior provider was an ObGyn with 16 years of practice.
### Table 3.1 - Participant Overview

<table>
<thead>
<tr>
<th>PACP Group</th>
<th>Recruitment total</th>
<th>Participant ID</th>
<th>Place of training</th>
<th>Years of Practice</th>
<th>Years in Greater Vancouver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Physicians (FPs)</td>
<td>5</td>
<td>1</td>
<td>Ontario</td>
<td>3 years (plus 2 years Residency)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>Ontario</td>
<td>8 years</td>
<td>5 Years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>Vancouver</td>
<td>2 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>Vancouver</td>
<td>3 years</td>
<td>1.5 years (not including training)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>Alberta</td>
<td>7 years post-Residency</td>
<td>6 years</td>
</tr>
<tr>
<td>Registered Midwives (RMs)</td>
<td>4</td>
<td>6</td>
<td>Quebec</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7</td>
<td>Vancouver</td>
<td>8 years</td>
<td>7 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8</td>
<td>Vancouver</td>
<td>2 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>9</td>
<td>Vancouver</td>
<td>12 years</td>
<td>10 years</td>
</tr>
<tr>
<td>Obstetrician-Gynecologists (ObGyns)</td>
<td>3</td>
<td>10</td>
<td>Vancouver</td>
<td>17 years</td>
<td>Residency in Alberta</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11</td>
<td>Vancouver</td>
<td>5 years Residency</td>
<td>(finished in 2016)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12</td>
<td>Vancouver</td>
<td>15 years</td>
<td></td>
</tr>
</tbody>
</table>

3.2 Qualitative Findings

The Interpretive Description of verbatim transcripts of interviews with twelve Primary Antenatal Care Providers (PACPs) was approached inductively. The exploration of participants’ attitudes and perspectives regarding anxiety and depression (AD) during pregnancy, how it’s addressed, and where (and how!) they require support revealed the following inter-related themes and sub-themes, including participant attitudes and perspectives toward:

1. anxiety and depression within their practice, including perceived prevalence;
2. identifying anxiety and depression during pregnancy through standardized screening and/or other means;
3. anxiety and depression management during pregnancy and perceived responsibilities;
4. existing supports and resources to support mental health during pregnancy;
5. gaps in care and primary antenatal care provider capacity to address anxiety and depression during pregnancy;
6. what could help PACPs and PP address anxiety and depression during pregnancy;
7. knowledge implementation in primary antenatal care settings, and their needs therein.

All participants were asked questions in a sequenced manner building from their perceptions of AD during pregnancy, and how they identify and manage cases of AD, toward what would support them in doing so (i.e. knowledge needs). This was done in the interest of understanding why and how AD during pregnancy is a persistent problem (i.e. barriers), and how to best support PACPs in addressing them (i.e. facilitators). The results culminate in participants’ knowledge needs and values – important determinants of and insights for knowledge-to-action regarding mental health integration in perinatal care settings

3.2.1 Attitudes and perspectives toward anxiety and depression within their practice

When discussing anxiety and depression (AD) during pregnancy, participants noted how pregnancy offers an opportunity to identify and manage mental health concerns, be they pre-existing, exacerbated during pregnancy, or manifesting during the perinatal period. As illustrated by this FP:

“[…] many people are just anxious or stressed in general […] I do think that pregnancy could be a really great opportunity to take a pause in some of those ways.” [4, FP]

Unfortunately, throughout interviews Primary Antenatal Care Providers (PACPs) reported not feeling equipped nor prepared to facilitate the potential this opportunity offers. They described experiencing much worry regarding pregnant people’s (PP) health outcomes and their capacities
to address AD during pregnancy. This is evident in how participants reflected on their experiences in identifying and managing AD with PP in their practices.

3.2.1.1 It’s a common experience among their patients

Participants reported seeing anxiety and depression (AD) habitually in their care settings. I asked: “how often/regularly would you say you encounter people experiencing anxiety and/or depression during pregnancy?” Generally, irrespective of the clinical setting, all providers (FPs, ObGyns, and RMs) considered AD issues they encounter “Regularly. [...] Like, it’s common.” [6, RM] Some spoke of AD during pregnancy as omnipresent, noting they see it constantly, especially since it seems to be on the rise and not specific to post-partum. As this participant explained:

“[it’s] always something for me. I’m always thinking about it. It’s not just a postpartum thing. Um, for so many people I see it’s an antenatal issue [...]” [2, FP].

Concern about rates increasing was evident throughout PACP groups. However, theories regarding why they were seeing more of their patients experiencing anxiety and/or depression during their pregnancies varied. Most either attributed it to “[...] over-pathologizing normal mood.” [8, RM] and/or they “[...] think there is definitely more of an awareness [of mental health] and willingness” [9, RM] to disclose. This demonstrates a tension between the normalization of mental health challenges during pregnancy and the problematization of its prevalence.

Interestingly, some PACPs noted that the Greater Vancouver Area seems to have disproportionate rates of AD. Those who made this distinction reflected on their experiences and deemed Vancouver different – a city with a generally anxious feel to it. As this FP with experience working with remote populations explained:
“[…] in Vancouver, I see a, I feel like I’m seeing a lot more people that are really stressed out. Whether you call it an anxiety disorder, or whether you don’t actually give it a name […] just the overall vibe is a lot more anxious.” [4, FP]

3.2.1.2 Pregnancy is a vulnerable time

Differentiations between AD being pre-existing or developing during pregnancy were made by some PACPs. FPs and ObGyns did so more often than RMs. As the following ObGyn noted:

“I would say most of them are pre-existing and then some are pregnancy induced, but most pre-existing.” [12, ObGyn]

This may be because they have established relationships with the pregnant people (PP) they follow from their general or gynecological practices (respectively). FPs tended to explain the complexity within these differentiations, noting how PP’s circumstances contribute to AD, pre-existing or otherwise. In some cases, PP may have been anxious or depressed prior to being pregnant but may not have been aware (and became undeniable in pregnancy). Some PACPs conceived of AD as developing throughout the perinatal period or as pre-existing challenges being exacerbated during pregnancy:

“I would say that like… If I see 25 women in a day, typically I would say at least 3 to 4 of them have some sort of past history […] but I’ve had… a couple women whose mental health ha – has very significantly deteriorated in pregnancy.” [1, FP]

Unlike FPs and ObGyns, RMs’ relationships with their PP are usually new (with the exception of PP who are multiparous and/or been their clients before). So, unless PP (or their referring clinician) disclose pre-existing conditions or they’re seeing the same RM for a new
pregnancy, most cases have to be identified by the RM/s during the relatively short period of their care relationship.

“[...] probably 4-5 out of 10 [...] had identified that they had depression and anxiety [...] and they were like aware of it [...] and then other people, sometimes things did develop in the pregnancy.” [8, RM]

Thus, most RM participants reported relying on encouraging disclosures of mental health history and/or concerns within their first visits with PP. Most RMs claimed to stay vigilant throughout the pregnancy for signs for concern. Among all PACPs, stressors associated with social circumstances during pregnancy were raised as proponents of AD that may go unnoticed or unrecognized prior to pregnancy and “[...] then get exacerbated during the pregnancy.” [2, FP]

Indeed, the perinatal period was considered a vulnerable time with pregnancy-specific factors to be mindful of. Participants referenced multiple and varying sources of stress that arise as PP’s bodies and circumstances change (accommodating and planning for an expanding family). As this RM put it:

“[...] being sad of the life you left behind, and being anxious of what’s going to happen, being afraid of giving birth, you know, like, having all that tension, not knowing, all those things can bring up very normal and health uh... emotions.” [RM, 6].

How social positionality and the identities PP embody (i.e. race, economic status, etc.) shape these stressors were also noted.

3.2.2 Attitudes and perspectives towards identifying anxiety and depression during pregnancy

The primary antenatal care providers (PACPs) interviewed described approaching the identification of anxiety and depression (AD) with the pregnant people (PP) in their care through
different means. They do so however they can and perceive is appropriate for the PP. That’s to say, they reported employing whatever they felt most comfortable with (perceived to be safe and efficient) and tailored their approaches to specific PP’s needs. Irrespective of the approach, all participants described relying on their dyadic relationships (PP-PACP) and the trust fostered therein to detect causes for concern and/or encourage disclosures of them. For some, this involved screening using standardized tools while others rejected this approach altogether.

3.2.2.1 Through standardized screening

In British Columbia (BC), screening using the Edinburg Postpartum Depression Scale (EPDS) has been recommended to increase rates of identification. All PACPs have the EPDS in their antenatal care forms, prompted to administer it between 28-32 weeks gestation (as well as once postpartum). However, PACPs reported using the EPDS during pregnancy differently (if at all), asking their patients to complete it under their supervision, assigning it as homework, or using it selectively (i.e. with some but not all their clients). Our discussions revealed this is illustrative of their attitudes regarding the relevance, reliability, and safety of standardizes screening. We focused on the EPDS as it’s the one they are prompted to use in their care forms.

3.2.2.1.1 Perceived relevance and validity of screening tools

Participants often reflected on how trustworthy they found screening tools to be – specifically the EPDS. Commonly, they expressed skepticism about relevance and validity (in relation to their clients). When talking about the EPDS, these concerns amounted in a general distrust of the tool and its ability to identify anxiety and depression (AD) effectively with PP. As an ObGyn with 16 years of experience said:

“All of our patients were supposed to be filling it out, but it didn’t seem to be identifying things particularly well for us.” [10, ObGyn]
Relevance was most often called into question when talking about the diversity of needs throughout PP populations. The most commonly noted differences among PPs were socioeconomics, English proficiency, and culture (heritage, ethnicity and immigrant status). Each present special considerations for the relevance of a standardized tool and the identification of mental health concerns:

“I have to be honest [...] I just feel my population is so variable [...] some patients, English is their second language [...] socio-economically they’re all very different [...] I guess I don’t really trust the validity of it. I trust my own clinical judgement” [10, ObGyn]

Most participants expressed preference for relying on their clinical expertise and dyadic relationships (rapport) with their PP to identify and address AD; both more amenable to a specific PP than a standardized tool. The recognition of different ways of being pregnant, meaning-making, and understandings of mental health (including attitudes such as stigma) among PP were reported as important to account for in screening processes. As this ObGyn explains:

“[ethnic minorities have] different understandings of mental health, [...] different ways of being in the pregnancy. Um... just, you know, a huge range of cultural affect even in pregnancy and through childbirth [...] makes it more difficult.” [12, ObGyn]

Currently, it seems that screening tools do not account for the variability in PP’s lives, experiences and needs. Although the EPDS has been “[...] translated into a number of languages [...]” [9, RM], this does not guarantee its meaningfulness nor relevance. Sentiments of futility and frustration concerning the EPDS were palpable in participant accounts. As one FP whose practice is primarily dedicated to immigrant and refugee populations noted:
“[...] it just kind of – it just never works. For a number of reasons. [...] I don’t use the questionnaires because they, they just never... it just doesn’t work. [...] depending on people’s cultural background, the concern of ‘in the last 2 weeks, have you felt X some number of times’ it, it just doesn’t compute in the same way. [...] it’s just that it’s really hard to use the scales in my settings [...]” [2, FP]

Indeed, many participants found the relevance and validity of screening using the EPDS suspect. For some, the use of such instruments universally despite – or without recognition of – diversity in ways of being, understanding, and needs, felt violent and harmful. This resulted an aversion to using standardized tools, and rejections of the EPDS in particular (refer to 3.2.2.1.2.). Generally, although some PACPs reported compliance with EPDS screening, many preferred diagnostic interviewing; taking a conversational approach to encourage disclosures. Others reported either screening selectively to supplement and/or confirm their clinical intuition or relying on other means.

Of the participants, FPs were the only group to mention using screening tools other than the EPDS to aid in their identification of AD with PP in their care, as illustrated by this FP:

“[...] I’ll use the GAD score for anxiety and the depression score as well. Like those are probably the two that I use the most: the PHQ and the GAD.” [5, FP]

Many favoured the PHQ (Patient Health Questionnaire) depression module, and the GAD (Generalized Anxiety Disorder scale) over the EPDS. This is likely due to them being the tools FPs use in their general practice. Physicians noted the PHQ and GAD are readily available in the EMR (electronic medical records system) whereas they’re unsure of where to find the EPDS. This familiarity equates to trust and reliance in their practice. As one FP explained:
“I’m just more comfortable with them [PHQ & GAD7] and also they’re in my EMR. Like, I just click a button and they’re there.” [3, FP]

The accessibility of tools and awareness of where to access them is thus another determinant of screening tool use.

3.2.2.1.2 Perceived [potential] harms of screening using standardized tools

Some participants reported refraining from using the EPDS due to perceived harms of screening using standardized tools. They expressed worry about isolating PP, giving them a stigmatizing label (i.e. mentally ill), and/or triggering the very issues they’re meant to identify, prevent, and manage. One RM referred to screening tools as “systems of triggers” [6, RM] adding “I feel like it is quite isolating, and I feel like it is quite stigmatizing.” [6, RM]

This was reiterated by another:

“I do find that [screening] does trigger quite a bit.” [9, RM]

Participant worries of triggering mental ill-being in PP were exacerbated by a perceived lack of responses to identification and guidance toward response options. When care providers aren’t given a “clear response” [6, RM], they consider it unsafe to administer screening. We will revisit this notion deemed the “then what?” later (in 3.2.3.4.) when discussing the management of AD in perinatal care. As this RM explains:

“[it’s] actually not safe to do [because] when a patient is triggered it’s when they are more at risk [...] and we are triggering people left and right [...]” [6, RM]

Consequently, these PACPs prefer other approaches to identification that do not rely on standardized tools. Discussing mental health openly with PP was considered less alienating than handing over a screening tool (to be completed under their supervision or as homework), which was referred to by a few participants as triggering. By relying on their PACP-PP dyadic
relationships, participants reported creating a safer space for identification. They explained how dialogue feels innocuous (safe) whereas tools feel official (intimidating). Depending on the approach, PP are perceived to be more or less likely to talk about their worries, stresses, and concerns. Participants consider how they approach identification of AD with PP important as it is the first step toward management and supporting PP toward good perinatal health outcomes.

3.2.2.1.3 Using screening tools selectively

Given participant concerns regarding screening, some reported they: “[…] do not do it on every single woman.” [1, FP], “[…] almost never use it.” [10, ObGyn], or do not use it at all. Throughout PACP groups, there was much variability in screening tool use. Often, time was identified as a determinant of screening in-clinic, irrespective of the PACP group. Although FPs and ObGyns have shorter appointment times, ranging from 5 to 15 minutes in length, RMs – who have 45 to 60-minute appointments – also noted time as an issue:

“[…] we for sure do it with everybody but some people we have them fill it in in the office if there’s time. […] some of my practice partners, um… give it as homework […]” [7, RM]

Another determinant of screening tool use was the perceived value of its role. Some PACPs considered the EPDS helpful in identifying PP experiencing anxiety and/or depression and as a benefit to their practice. As one FP said:

“[…] I think there is absolutely a role for questionnaires […] you can get a lot more history about what a woman’s going through and a lot more nuance […] getting a sense also of what’s going on.” [1, FP]

However, that same FP “[does] not do it on every single woman.” [1, FP] but likes to use it as a means “[…] to monitor and track it over time […]” [1, FP] This brought in another selective
practice: repetitive screening for tracking purposes. This approach was used and adapted by some PACPs who employed screening instrumentally to facilitate conversations about mental health, supplement history-taking, and track and monitor mental health. Still, the use of the EPDS was contingent on when PACPs perceived having time. Consequently, participants described gauging the use of the EPDS relative to how worried they were about a PP in their care and to aid in discerning “[what] is best for the woman in front of you [...]” [1, FP]. For instance:

“I use it if I’m concerned [...] if there is a hint of depression/ anxiety in the room, I will, I will administer it” [3, FP]

In this way, participants used the EPDS to supplement their care and validate their clinical intuition. Of all the PACPs, FPs used screening tools most. Often, they reported using other screening tools they bring into their perinatal care from their general practice (e.g. GAD; PHQ) in these ways.

3.2.2.2 Through other means

Of the PACPs interviewed, those who complied with EPDS screening for AD during pregnancy were the minority. The majority had alternative means of identifying when their clients were experiencing AD, favouring approaches that rely on their clinical intuition, expertise, and PP-PACP dyadic relationships. Many participants explained how they would rather ask their clients about how they’re doing and what they need through dialogue. As this ObGyn explained:

“I trust my own clinical judgement [...] I talk to them and assess them.” [10, ObGyn]

This approach felt less isolating than a self-assessment tool and/or raising the topic when PP may not be ready.

3.2.2.2.1 Using clinical judgement and seeing the signs
As previously noted, participants perceive AD to be prevalent and something they keep in mind when supporting PP throughout the perinatal period. As such, most reportedly stay vigilant and look for signs to indicate causes for concern or worry. As a RM noted “There’s signs.” [6, RM] that indicate when PPs require assessment to avoid mental health worsening. According to participants, seeing the signs incites concern in PACPs and influences their course of action. In other words, when PACPs identify they “[…] would be quite concerned about this patient […]” [10, ObGyn], they gauge what their next steps should be, including what to refer PP to (management).

Signs were usually identified either as risk factors PP enter perinatal care with, or flags that are raised during pregnancy. Risk factors are circumstances that “[…] set up [PP] for having some trouble.” [10, ObGyn] during pregnancy. The most commonly mentioned were previous experiences of anxiety, depression or other mental health concerns, advanced age, personality type (e.g. “type A”), PP’s journeys to pregnancy (fertility) and through previous pregnancies (loss). Other predictors of AD noted by participants included social isolation (e.g. not having family nearby), and socio-economic status. Participants noted these factors were often exacerbated by pressures and expectations PP experience regarding pregnancy and parenthood:

“[...] lots of expectation and ... pressure put on herself by herself and also by society.” [10, ObGyn]

These also affected PP who did not present the risk factors most noted by participants. Thus, PACPs described how they look out for and interpret changes in function and affect as flags raised and signs for concern. Of the participants, FPs used the term “function” most, noting the signs they stay wary of as “[…] some sort of like dysfunction in her life usual activities.” [1, FP].
These signs were considered reasons to raise the topic of MH among participants. As this FP explained:

“[…] for mental health, that’s usually a sign that, um, something needs to be addressed is when people are struggling with their normal function.” [2, FP]

Although FPs used the term function the most, all PACPs look out for anything that’s “[…] so radically out of her normal disposition that there’s something to ask and investigate […]” [6, RM], such as “a big change in behaviour.” [7, RM] or “[…] when someone’s pattern of behaviour is not usual.” [7, RM]

How PACPs investigate these concerns vary, with some participants using screening tools while others favouring a diagnostic interview approach (dialogue). Generally, PACPs noted how an absence of risk factors or flags for concern does not clear PP from experiencing AD during pregnancy. As this FP put it:

“[…] not having any risk factors doesn’t like exclude the possibility of you having like a serious mental health concern in your pregnancy.” [1, FP]

Irrespective of the constancy of a PP’s behaviour, they “[…] would make sure to ask about, um, function in her life in general […]” [3, FP] According to participants, this requires finding opportunities to encourage disclosures.

3.2.2.2 Relying on person-provider rapport for disclosure

Whether prompted by their antenatal care forms or by seeing concerning signs, participants reported relying much on the trust and rapport fostered in their PACP-PP relationships to start and sustain conversations about mental health. Antenatal care forms include opportunities to talk about mental health within the first few visits while taking PP’s histories, and at 28-32 weeks when the EPDS is meant to be administered. However, given the newness of
their relationships with PP (unless they’re a returning client) and the vulnerability inherent in revealing mental health challenges, disclosures at their history-taking visits were reportedly few and far between. Some noted how this does not stop them from making time for the topic, noting “[we] have lots of opportunities to check in [and] ask questions” [9, RM]. For instance:

“[...] around 8-14 weeks, I first broach the topic on mental health as a general discussion item. I usually ask: what do you do to support your mental health?” [9, RM]

Some PACPs decide to center the subject at a visit dedicated to it. As this RM explained:

“So, I usually have at least one whole visit where the theme [...] The theme is mental health and preparing for postpartum [...]” [9, RM]

Being the PACPs with the longest visits, RMs tended to report there being ample opportunities to talk about mental health with PP. As this RM appreciated:

"[...] as a Midwife, we’re, we’re even, we’re even more fortunate because we spend more time with people. So, we have... just the luxury actually compared to other care providers of time to address things and to provide, you know, preventative kind of support.” [8, RM]

PACPs with shorter visits (FPs and ObGyns) reported much difficulty integrating mental health into their practices (i.e. professional demands and time pressures). This is discussed further below (in 3.2.4.2.). Generally, all participants described how they look for opportunities and find ways to discuss mental health with PP. They consider these moments valuable for normalizing and demystifying mood and mental health (3.2.3.2.) in the interest of encouraging disclosures. The effectiveness of how PACPs use these opportunities is reportedly reliant on the quality of their relationships with PP and their ability to create a safe space for identification and/or disclosures of mental health concerns. Rapport, trust, and finding or choosing chances to
start a dialogue as organically and invitingly as possible was considered essential by all. Cumulatively, this meant that PACPs often attempted to find innocuous ways to initiate the conversation (to avoid isolation/ alienation). As this RM does:

“I do a lot of work with food [...] you know, unbalanced blood sugar you know, like our mood goes up and down [...] and that’s also like a way for me to then talk about her mood.” [6, RM]

Some PACPs reported that sometimes this opportunistic approach was less about directly addressing a sign or red flag, and more about ensuring that PP knew they were available, and the topic was approachable. As this FP said:

“[…] my usual approach to patients in general is trying to be quite open and receptive so that visits can flow organically and PP feel comfortable to bring up more vulnerable topics more comfortably and together we can engage in open conversation.” [4, FP]

This approach shifts the onus to the PP to bring up concerns since the PACP has established that it’s a welcome topic. So, while they passively create the space to talk about mental health, they are relying on PP to disclose rather than broaching the subject themselves. A more direct way to invite PP to disclose was to ask how they’re coping. Reportedly, this helps PACPs discern what could be causing and/or contributing to PP’s stress. As this ObGyn with 14 years of experience explained, she asks:

“[…] how are they coping, what’s bothering them […] sometimes it’s family stress, sometimes it’s work stress, relationship stress […]” [12, ObGyn]

According to participants, this information grants them the ability to deduce what supports PP are in need of. In other words, identifying where stress is coming from can guide PACPs toward
where PPs require most support. Some participants offered their reasoning for this approach, such as:

“[...] it’s far less stigmatized to sort of [ask]: how are things going at home?” [2, FP]

However, participants emphasized how all PP hold different attitudes toward pregnancy and mental health. Some reflected on the complexity of addressing AD with different PP and the challenges in communication therein:

“one of the things [PACPs] find challenging is that [...] there’s different ways that you can check in with people and people respond very differently to different types of communication.” [8, RM]

A significant consideration is stigma, the resultant negative perceptions of AD, and reluctance to talk about it. As this RM explained:

“[there’s a] fine line between trying to help and offending people” [7, RM]

For those experiencing AD, stigma can manifest in avoidance (in talking about it, and in seeking support). As this RM shared, PP can be

“[...] in denial for quite a long time. Until it’s undeniable and no matter how many times you talk about it [...] you just don’t want it to be you!” [8, RM].

Certainly, isolating clients is a troubling notion to all. So, as this ObGyn put it: “[you] have to be careful how you approach it with them and their partners [...]” [9, ObGyn] and must adapt accordingly. As this Midwife shared:

“[...] sometimes you do have to ask it in different ways [...] So, learning how to find other language, um.... To, to try to get more information.” [7, RM]
This challenge is considered especially acute when working with immigrants, refugee, and Indigenous families as they have different ways of meaning-making and being during pregnancy as well as varying perceptions of mental health. As this Midwife explained:

“[…] cultural differences [...] maybe the words that she used and the, uh, emotion that she’s expressing like, the behaviour she’s expressing does not translate […]” [6, RM]

Adding:

“[…] one of the barriers are cultural and language and um, socioeconomical [...] if you’re already from a stigmatized community, it’s hard to speak out because you don’t want to stigmatize your community even more [or] you don’t want to stigmatize yourself even more […]” [6, RM]

One FP who has experience working with various First Nation PP’s, including from Vancouver Island, raised the issue of having limited understanding of where AD is coming from. Especially when the PP are from systemically marginalized groups, such as cultural minorities including Indigenous peoples. She explained:

“[…] people with really complex social life situations and maybe a number of diagnoses that may or may not be correct because really underlying it’s, it’s trauma or foster care or, or, or [...]” [4, FP]

Given the complexity of identification and the nuances in approaching needs, participants expressed they would appreciate some insight from PPs to inform these conversations (to encourage disclosures). Especially since “[…] as providers we can sometimes see things in different ways than patients can and which is why you need at least both views equally.” [4, FP]
This is indicative of how PACPs recognize the important role they play as determinants of health and how mindful and careful they must be to ensure they’re promoting good outcomes. As this RM reflected:

“[…sometimes we’re just not aware, like you know? Sometimes we are the perpetrators that make them feel isolated and disempowered and silenced […] Of course, that’s not my wish, but I’m sure I’m part of the problem, like that’s for sure. […] There’s a lot of psychological violence […]” [6, RM]

Generally, PACPs rely on their relationships with PP to direct their efforts, minimize the likelihood of alienating or isolating PP, and increase the chances of PP disclosing how they’re feeling and coping. Although difficult to navigate, participants still prefer these approaches as they lend themselves to in-depth conversations about AD management.

3.2.3 Attitudes and perspectives towards anxiety and depression management during pregnancy

How participants approached the management of AD during pregnancy often affirmed the strategies they reported using to identify PP experiencing them. Person-centered considerations to care were discussed most often. Again, dyadic relationships were fundamental to their approaches.

3.2.3.1 The need to tailor for relevance

In recognition of each PP’s unique situation, participants repeatedly noted the importance of tailoring their approaches for relevance in the interest of effectiveness (from identification to supporting management). As illustrated by this ObGyn:

“[…] it’s very… it’s somewhat patient-specific in how severe it is [and] it depends very much on the patient and on their situation [so] the important thing is to assess it and
then, and then figure out with each individual patient what's going to work.” [10, ObGyn].

Indeed, given the complexity and particularities of every PP’s circumstances (i.e. age, heritage, migrant status, socioeconomic status, etc. and the intersections therein) most participants echoed:

“[…] you have to tailor it to each patient.” [10, ObGyn]

The consensus being that when relevance is lacking, approaches to care are less likely to be salient or meaningful to PP. Consequently, efficiency and effectiveness of management strategies and supports are compromised and so too are perinatal health outcomes. Thus, participants described the role of tailoring in trying to facilitate their clients’ best chance. As this RM said, it takes

“[…] kind of customizing that person’s situation so that they have the best chance at... keeping that depression and anxiety at the lowest level it can be.” [9, RM]

However, given the variability in PP circumstances, this is not easy. As this FP shared:

“[…] trying to navigate and see which is best for the woman in front of you is challenging.” [1, FP].

This challenge is reportedly compounded by a perceived lack of resources specific to mental health during pregnancy. Most participants reflected on this added layer of complexity in supporting PP experiencing AD, noting how they direct their efforts relative to “what their options are and what – you know what resources they have to put into their own mental health.” [5, FP]

Preoccupations regarding the relevance of resources and availability of options resurfaced. Participants reported that even when options are available, access can still be and is often hindered. Some examples offered by participants include:
(1) PP accepting or rejecting PACP recommendations, usually based on personal values. As this ObGyn explained: “[...] I’ll offer them mental – Reproductive Mental Health for sure, but a lot of them won’t/don’t want it” [10, ObGyn];

(2) PP having a difficult time navigating our healthcare system. As this FP said: “[...] people get confused with how to navigate the system or don’t necessarily know how the system works.” [2, FP] and/or affording what the system offers;

(3) PACP familiarity with what’s available. As this FP confessed: “[...] if they are part of a minority group, I have no idea what cultural or community resources exist, so that’s a barrier.” [3, FP]

All have implications for how well what exists gets used. As explained by this FP:

“[...] we don’t necessarily take advantage of all the things that are available [...]” [2, FP]

Participants reported persistent worry about how to avoid alienating PP, how to support them given the many things that contribute to stress, and the particularities each PP has regarding how they can be helped. Ultimately, many reported feeling overburdened with responsibility in addressing AD during pregnancy (and minimizing the resultant adverse health outcomes). This will be expanded in section 3.2.4.3.

3.2.3.2 The need to manage expectations and normalize emotion

Participants described endeavouring to educate, reassure, and empower PP throughout the perinatal period. Their perceived need to manage expectations and normalize emotion plays a role from prevention, to identification (3.2.2.2.), and management. Some started these conversations within their first visits while others waited for concerns to surface. For instance,
this RM initiated normalization when taking PP history, which usually includes questions about mental health history (per prenatal care forms):

“[…] in the first couple visits we usually take a history for people [and] I mention: just so you know, pregnancy and the postpartum period there is – we see an increase, slight increase um, of anxiety and depression […] So, just know that it exists […]” [8, RM]

This ObGyn echoes this sentiment, reassuring PP that “[…] if there’s any changes in their mood it can be related to the pregnancy and I just would like them to talk to me about it.” [11, ObGyn]

Participants reflected on their role in dispelling dominant socio-cultural narratives that portray pregnancy, birth, and parenthood in ways that are detrimental to pregnant people (PP)’s mental health (pressures). As this FP described:

“[…] especially when society and this culture is telling you so many things about how you have to be as a mom and like there’s so many outside pressures that I think just add to it that aren’t helpful. So, I mean, what would help? Like, changing that!” [4, FP]

However, there are external factors that make this difficult and/or frustrating for PACPs. For instance, publicly-available information – particularly on the internet – can uphold misinformed ideations of pregnancy (what to expect during and after). As this ObGyn expressed:

“[…] trying to veer them away from the misinformation that’s on the internet. This is a lot of pressure on women to do everything perfectly during pregnancy and the reality is it can be a lot harder than expected and that the expectation that are created are unrealistic. Makes me crazy, actually.” [10, ObGyn]

According to participants, pressures to adhere to such expectations are compounded by mental health stigma, and vice versa. Romanticized notions of pregnancy, birth, and entering parenthood leave little room for PP experiencing stress to have compassion for themselves.
Consequently, participants often found themselves having to support PP in reconciling what they anticipated (romanticized) with what they experience (unknowns and stress). As this Midwife explained:

“[...] when they over-idealize their birth and their postpartum and they have no concerns [...] like, there’s so much tension, there’s so much pressure, there’s so much unknown and all explode [...] it’s like that, that fine balance of normalizing and yet... being aware.” [6, RM]

Participants often took on the responsibility to normalize AD during pregnancy, without triggering either, while educating PP on the likelihood of experiencing them – all toward empowering PP to face the big changes they’ll be undergoing with resilience. Indeed, they shared how they demystify the likelihood of experiencing AD, considering how they “[...] can affect anyone at any time, regardless of who you are [...]” [9, RM]. In fact, one RM explained how if PP did not exhibit any stress related to their journey through pregnancy, she would consider them at risk of AD, stating:

“[...] being sad of the life you left behind and being anxious of what’s going to happen, being afraid of giving birth, [...] not knowing and all those things can certainly bring up very normal and healthy emotions [...] I would actually be concerned if you were not concerned [...]” [6, RM]

As per their identification tactics, PACP-PP rapport is important in facilitating these conversations. Ultimately, participants explained how they balance reassuring PP by “[...] let[ing] them know that it’s common” [3, FP], they are there for them, and they’ll “[...] figure it out together.” [8, RM] with competing clinical demands.
In general, participants described how they relied on the management of expectations and normalization of perinatal AD as a means of prevention, promotion, identification, and management, helping PP cope with emotions/moods they had not anticipated (instilling self-compassion).

### 3.2.3.3 What supports and resources exist to support mental health during pregnancy

Participants were asked what resources they rely on and refer to for AD management. The one free, pregnancy-specific mental health resource in Vancouver, Reproductive Mental Health (RMH) was referred to the most. This resource does not limit its services to pregnancy; they provide mental health supports throughout the reproductive cycle, from premenstrual syndrome to menopause. Participants described how the combination of mental health care not being covered, and this resource being highly sought after introduces barriers in access, such as long wait times. For example:

> “It can be a bit of a long wait to get them in to see Reproductive Mental Health. [...] often there’ll be a 3-6 month wait [...]” [12, ObGyn]

This resource is coveted as they understand the particularities and specific needs of those experiencing MH challenges and concerns throughout the perinatal period. As this ObGyn explained:

> “[...] they kind of understand the acuity and compressed timeframe of a pregnancy that other mental health providers appreciate but can’t manage.” [11, ObGyn]

However, she went on to lament: “[...] Repro Mental Health is it.” [11, ObGyn] As the only resource PACPs know is specific to PP needing mental health supports (and is free), waitlists are seen as a frustrating inevitability. This calls into question how reliable it is. As this FP noted:
“[…] sometimes it’s a 6 month wait and then well, there’ll already be – they’ve already had their baby […] it sometimes is useful. Sometimes not as much.” [5, FP]

Essentially, RMH is a resource and MH facilitator when it’s an available option (in acute/priority cases). However, since it’s often unavailable (i.e. long waitlists) a barrier is presented and PP’s needs go unserved. Participants reflected on how this is the case with most resources and facilitators, noting how their capacity to serve as supports for perinatal MH is compromised by barriers. In the case of RMH, waitlists are the main barrier.

In the meantime, or in lieu of, participants reported counselling PP and recommending other options, including AD self-management Apps, books, prenatal classes, and therapy (see appendix J). However, according to participants, these strategies do not assuage their worry as each option presents barriers to use spanning acceptability by PP (relevance to them), affordability, and motivation. Generally, PACPs’ responsiveness to the needs of PP experiencing AD is compromised by a perceived lack of accessible pregnancy-specific mental health supports. Counselling is a resource participants often considered “[…] should be covered” [8, RM]. In fact, at least one participant emphasized the importance of having access to counselling through pregnancy, saying:

“[…] everyone could probably benefit from CBT [cognitive behavioural therapy] and counselling that was covered by MSP like in general in their life and especially if you’re pregnant […]” [4, FP]

Certainly, the fact that mental health is not covered was a big frustration among participants. All PACPs thought of it as a necessity given their perceived lack of training (3.2.4.1.) and low levels of adherence to self-management by PP. Although physicians can prescribe and manage pharmaceutical treatments for mental health concerns, frustrations
associated with the prohibitive expenses of therapy remain. One RM expressed how confounding this situation is:

“it’s weird that counselling isn’t... covered. Like, that mental health support that isn’t pharmacological isn’t covered.” [8, RM]

Participants considered the costs associated with supports and resources to exacerbate the issues PP have with accessing mental health care. Affordability is considered “[...] a big barrier in terms of therapy” [5, FP] as this RM said:

“[counselling] costs a considerable amount of money. Big bucks!” [9, RM]

Consequently, participants described making do with what they can offer within their visits. As this FP explains:

“what happens to me now is that I identify someone reasonably early in their pregnancy and try to refer them to Reproductive Mental Health and be told there’s a 4 month waitlist. So then... I just try to see them as often as I can.” [2, FP]

However, given the professional demands and time constraints participants reported, this approach is not considered sustainable (and in some cases, not feasible). According to those interviewed, PACPs are no strangers to compensating for a perceived lack of supports to facilitate their care of PP.

3.2.3.4 “Then what?” and the perceived lack of supports for mental health during pregnancy

When faced with a PP experiencing anxiety and/or depression (AD), participants described being confronted with much uncertainty regarding what to do once concerns have been identified. Particularly as they are not equipped with a clear response after identification. This
was commonly expressed as “then what?” – denoting an unfamiliarity with the next steps with their clients.

“[…] you screen somebody and then you’re like: “ok, like, you’re high risk” or “you’re low risk” but like and then what?” [8, RM]

When providers are not equipped with the tools to address concerns once identified, their capacity to address AD during pregnancy is gravely restricted. This introduces concerns of harm:

“[…] to do a scale and it’s actually accurate, but you don’t give me any tools to respond to that, then I actually think it’s more damaging” [6, RM]

When PACPs don’t have the “then what?” their only perceived course of action is to compensate and “[…] offer them [PP] an elevated level of overall like, clinical support” [9, RM] However, given competing professional demands (and the time limitations they impose), compensatory strategies are not preferred. Participants reported they’d benefit greatly from being directed to the “then what?”. Most confessed having limited awareness of what resources exist beyond RMH. According to participants, this would cut down on the time PACPs currently spend trying to find and appraise resources. As this RM explained, PACPs presently struggle to find “[…] time to deal with it, to think it through to… you know, look for resources.” [9, RM]

The time this takes to do this is not only considered inefficient, but also a deterrent to spending time to finding appropriate resources for those who need them. To inform appropriate referrals and minimize the burden of care on them, participants emphasized they “[…] need to know everything that is available.” [3, FP]. Many echoed the request: “[…] educate us on what are the new resources available […]” [3, FP] as “[…] awareness is… huge.” [1, FP] Reportedly, awareness of the “then what?” – the options therein, how to access them, and how they’ll benefit PP – is essential to the care PACPs offer. Throughout interviews, participants highlighted
needing more than one option (i.e. RMH) and more pathways toward accessing mental health resources (and becoming aware of them!). As this RM said:

“I would prefer to see something that’s more like: ‘here are some tools you can use’ rather than: ‘this is the one thing you should do with everybody’.” [8, RM]

Only having one thing (resource) to refer to is perceived to be a problem in many ways and for many reasons. Notably, the wait times mean PP risk going without mental health support for weeks or months. This was disconcerting to all participants as the adverse outcomes of underserved mental health were well-known. If alternatives to RMH cannot become available, PACPs expressed needing strategies and options in the interim – during the wait; between identification and referral. As this FP expressed:

“[…] I mean, I guess also it would be nice if there was some way to know like, for instance Reproductive Mental Health is definitely a resource, but then what do we do during 16 weeks that we’re on the waitlist?” [2, FP]

Later reiterating: “[…] I need something better than a 16 week wait […]” [2, FP]

The presence of the “then what?” throughout interviews is illustrative of how PACPs’ needs to support PP’s mental health are not being met. This is reflected in how participants’ accounts reflect feelings of worry and being over-burdened, compensating for a system that does not prioritize mental health nor allocates resources toward supporting it. In the words of the following Midwife:

“[…] the government decides how they’re going to fund us and what they’re going to pay for […] if they don’t put funding into programs to support mental health an wellness, then... then just the programs don’t exist for us to refer people to.” [8, RM]
3.2.4 Attitudes and perspectives towards the gaps in care and primary antenatal care provider capacity to address anxiety and depression during pregnancy

Participants reported feeling overburdened and unsupported as commonplace among PACPs caring for PP with mental health (MH) concerns. From identification to management of AD, participants highlighted the responsibility they shoulder in creating space for both. When asked about facilitators to their care of PP experiencing AD, many participants had difficulty noting any. A few explicitly said there are none. When clarifying that facilitators referred to “something that is currently working” this ObGyn simply answered “No.” [ObGyn, 11] In most cases, what could be a facilitator currently manifests as a barrier. For instance, time (e.g. professional demands) and money (e.g funding) are considered necessary to create spaces to address MH during pregnancy, but the perceived scarcity of them reframes them as barriers. This is especially worrying to PACPs delivering care in Greater Vancouver as participants reported having highly diverse patient populations (particularly regarding economic status and cultural relevance). The perceived relevance and acceptability of resources were recurring concerns among participants. Most considered there to be a lack of options for their patients. As this FP shared:

“[…] I do feel like there’s not many options. Um, so that also frustrates me […]” [4, FP], and that “[…] if there are I don’t know about them and that most of them are private pay […]” [4, FP]

Although Reproductive Mental Health (RMH) is a resource, most participants struggled to reconcile the futility of referrals to it with their clients’ needs. Most participants considered accessible resources scant and existing programs to lack pregnancy-specificity (apart from RMH). As this ObGyn explains, PP’s mental health is underserved as
“[…] nobody really seems to see pregnant women […] I’ve usually found that most of the resources are not really suitable for pregnant women. […] they just don’t deal with pregnant women.” [11, ObGyn]

Participants recognized this perceived insufficiency may be attributed in part to a lack of awareness of what’s available on their part. As per PACPs’ preoccupation with the “then what?” (3.2.3.4.), supporting their awareness of resources was considered invaluable to facilitating the mental health of PP.

Contrastingly, a FP who had trained rurally considered Greater Vancouver rich in resources. In her own words:

“[…] there is actually stuff that you can access. […] So, I think being here and like having some programs that already exist… is a huge facilitator […]” [1, FP]

Additionally, a few FPs and ObGyns reflected on the systems they use for referrals and the perceived ease (and convenience) of using them. As this ObGyn explained:

“[…] all of it is easy to refer to. The whole system is pretty easy. It goes through my EMR.” [11, ObGyn]

Other pathways for referrals included “R.A.C.E. Rapid Access to Consultative Expertise […]” [1, FP] and “[…] Seamless Perinatal. […]” [12, ObGyn]. Still, participants made a distinction between being able to make a referral, and PP accessing the care they need. To use Reproductive Mental Health (RMH) as an example, participants reported referring to it often, but PP go months on waitlists.

Many reflected on and described how they try to compensate for a perceived lack of external resources (to refer to and PP to access) and internal resources such as training, clinical experience, and time. All of which shape PACPs’ capacities to address AD during pregnancy.
3.2.4.1 Gaps in training

Although experience grants PACPs certain competencies, most participants acknowledged feeling unprepared to provide the care PP experiencing AD need. As this RM explained:

“[…] our training isn’t fantastic […] there’s one counselling course that’s required” [7, RM]

Indeed, many reflected on a lack of training and how it shapes what they can offer their clients. As this RM illustrates:

“I do find sometimes I, I don’t have the skills to really work deeply with people like a counsellor would.” [9, RM]

Not having the skills to help PP manage their mental health concerns is worrying to PACPs, especially since psychological counselling is inaccessible to many and AD predict significant adverse health outcomes. Further, it calls into question what is within the scope of their role. Generally, not meeting PP’s needs is a persistent preoccupation. As this RM reflected:

“Like, I’m not a counsellor […] when I’m trying to support someone through something I do kind of feel like: this person needs more support than I am able to offer.” [8, RM]

Participants often rely on the rapport in their PACP-PP dyadic relationships to aid in addressing MH concerns. Although PACPs worry, they certainly don’t want PP to. So, they try to “make them feel very safe” [6, RM], promising “we’ll figure it out together” [8, RM]. Within their dyads, professionally developed resources such as experience and clinical intuition are leaned on to identify and manage AD (and compensate for gaps in training regarding both). Participants emphasized that further supports are needed to lessen the burden on PACPs, PP, and
their dyadic relationships. Ultimately, participants “[…] all wish there was like even just a better guide for us […]” [8, RM].

A recurring concern among participants was that mental health is not integrated in perinatal care training nor clinical settings. Although some echoed the following ObGyn:

“I think most of us see [mental health] as part of our role already” [10, ObGyn]

Most recognized that not all PACPs view mental health as within the scope of their practice. For instance, this RM shared:

“[…] my experience working with other providers is that some people have also done what I have done and are very good at supporting people supporting… uh, prenatal, and anxiety and depression and postpartum anxiety and depression and others are not.” [8, RM]

Indeed, some noted how this contributes to a perception among PACPs that mental health as extra, and specialized work. As illustrated by this ObGyn:

“I provide general ObGyn services so I’m certainly not a sub-specialist in mental health […]” [11, ObGyn]

Viewing mental health as beyond their core practice was common. As this FP stated:

“Like, we have to see so many patients in a day […] but at the beginning and end of pregnancy [visits] become really long […] So… adding in more just takes up more time […]” [5, FP]

Participants described feeling overburdened with having to find the time to make up for limits to their understanding and awareness of MH (and resources to support it). Time is a coveted resource that participants implied has the potential to facilitate the closing of gaps, but currently exacerbates them.
3.2.4.2 Time and its role in gaps

Participants noted how time in visits is primarily focused on the physiology of pregnancy (gestation), or “the basics”. Given how most felt unprepared to care for MH concerns, many reported providing the care they felt competent and confident in and then dedicating time to exploring what PP’s MH needs are. As this Midwife described:

“[...] having the basic things taken care of. So, making sure they’re physically well. So, if they have any discomforts during pregnancy, you know, that they’re managed. [...] so that they have the best chance at... keeping that depression and anxiety kind of at the lowest level it can be.” [9, RM]

This points to some complexity in how physical health impacts mental health and vice versa, but PACPs are trained to take on the former. Still, that didn’t stop many from making do and integrating MH care into their practices however they could. Sometimes participants spoke of this with levity, like this ObGyn:

“I joke I provide gynae-chiatry services” [11, ObGyn]

This implies a lack of integration of MH in their training and clinical milieus (otherwise, the “chiatry” would be redundant). Even though some may think of MH to be within the purview of their care responsibilities, it is not perceived to be facilitated. Subsequently, it’s considered additional work by some (i.e. compensating for a lack of integration) – a deterrent to doing it. To them, their ability to allocate time to MH is undermined by a lack of systemic support to do so. As this RM put it, it’s difficult to do much when “[...] people, resources, money and resources that are... scarce.” [7, RM]. Time was often associated with money; a determinant of time spent on MH (e.g. incentivizing providers or funding supports). As this ObGyn explained, there is no
“[…] financial model for most physicians in the community to be doing um, the extra work like that.” [12, ObGyn]

Indeed, many participants reported feeling like taking the time to identify MH concerns, troubleshoot what’s available, and appraise what’s appropriate for the PP in front of them “[...] just feels like that’s like another task on top of things.” [8, RM]

Time was identified as a significant factor in PACPs’ capacity to address MH concerns with PP. Many considered time a potential facilitator, but a current barrier in addressing AD during pregnancy; there is no time to dedicate to finding what might be best for a specific PP. So, they rely on what they know. Some compensate by offering to “[...] spend more time with people, have more appointments, go do extra home visits. [...]” [8, RM]. However, neither are considered feasible nor sustainable logistically. Especially outside of Midwifery, where home-visits are not within the scope of practice (and deferred to community nurses). As this FP explained:

“[…] we have our set appointments for our regular prenatal visits and then to have them – I, I can’t see them for an extended period for time during the day. So, then I have to ask them to come back on another visit for a longer visit [...] and a lot of people don’t have time to come into the office [...]” [5, FP]

Even RMs whose visit times are significantly longer than the other two groups of PACPs (FPs and ObGyns) perceived time as limited.

Time spent on mental health training, time spent on identification, time spent on normalization of emotions/moods (prevention and promotion), time spent on empowerment, time spent finding appropriate resources, time spent on counselling, and so on is reportedly
unsupported in perinatal care contexts. Participants expressed worry about the role of time in gaps that persist in their care settings and in PP’s outcomes.

3.2.4.3 Gaps and the responsibility to fill them

The gaps described thus far have elucidated how participants perceived a disproportionate amount of responsibility befalling PACPs to address AD during pregnancy, picking up after where the healthcare system is failing them (as evidenced by a lack of facilitators) and where PP experiences are demanding care PACPs are not equipped to handle (i.e. lack of training). All participants considered pregnancy to be a vulnerable time and MH challenges to be commonplace. However, they also reported experiences of being overburdened with responsibility and worry in compensating for their perceived lack of capacity to prevent, identify, and manage AD with PP. As this FP said:

“I think healthcare providers take on a lot of responsibility and a lot of worry” [1, FP]

According to PACPs interviewed, external resources (i.e. pregnancy-specific MH supports PP can access) are lacking to supplement their efforts in addressing AD during pregnancy (integrating MH in perinatal care). This is also reportedly true of their internal resources, including time and training. In spite of the former and in response to the latter, participants recommended self-management resources to PP. Since their time together is limited and MH care is unaffordable to many, participants often encouraged PP to buy books, watch films, and/or download websites and apps (see appendix J). Again, the issue of pregnancy-specificity arises. At times, resources are specific to pregnancy, but exclude mental health (or vice versa). So, issues with integration, relevance, meaningfulness, and usefulness were ever-present and worrying to participants. Further, this approach burdens PP, placing the onus on them to pursue their own mental health. Some PACPs brought up how this is not a feasible
approach as PP are already overwhelmed by the “big change” [7, RM] and “big life transition” [8, RM] that occurs during pregnancy and preparing for parenthood (or another child). As this FP put it:

“[..] the antenatal period is very hard to come to terms with, because A. there’s just so many changes going on, mentally, physically, emotionally. It’s hard for people to even A. recognize that there is an issue, and B. sort of come to terms or accept that there might be an issue.” [5, FP]

This is particularly true for first-time/ nulliparous PP. As this RM said:

“[..] the first pregnancy you know, it, it’s a huge shock.” [9, RM]

Consequently, participants sympathized with PP as dedicating time to MH can feel daunting:

“[..] life gets in the way and it’s really busy and doing those extra things for yourself seem like more work.” [8, RM]

Certainly, participants recognized each PP experiences specific stressors and have more or less capacity to cope and manage. So, most considered empowerment of PP a necessary part of their roles. As this RM expressed:

“[..] I feel like women who have really good prena-postnatal care are very empowered, they understand, they’re quite self-aware.” [9, RM]

Self-awareness lends itself to identifying (disclosure) and managing MH concerns. Again, this requires PACPs finding the time to “[..] try to give them some education, empower them.” [10, ObGyn] Given restrictions on time, most participants echoed: “[..] I feel like I try to do my best.” [8, RM] Still, they recognize there are only so many gaps PACPs can try to fill.

Cumulatively, participants implied that what is working is only working because PACPs are making it work or trying to. This is overwhelming to many, as illustrated by this RM:
“ [...] there’s a lot of demand on us. ” [6, RM] later explaining: “[...] people [are] being really over-worked [and] the provider also needs more support and education, but also in their own, um, in their own mental health and exhaustion [...]” [6, RM]

This elucidates key barriers PACPs perceive in their ability to support their clients’ mental health, including gaps in resources (and their awareness of them), their training, and time to dedicate to MH in their care settings.

3.2.5 Attitudes and perspectives towards what could help address anxiety and depression during pregnancy

The gaps discussed above indicate areas where the systems PACPs work in could better support them and their capacity to address AD with PP. Although all participants described how they are trying their best, they also emphasized there is only so much they can do to integrate MH in their practices. In speaking to these experiences, participants referred to systemic factors they perceive as hinderances to their ability to support their patients’ MH. Group-specific concerns associated with different PACP governing bodies and billing structures were mentioned. However, the over-arching issues described by participants concerned demands of their professions (time constraints) and lacking support from the healthcare system. Most wished they had support to “make it easier!” [8, RM], equipping them with the training, time, and external resources they currently lack, especially given the perceived prevalence of AD during pregnancy. As this RM said:

“ [...] perinatal depression is the number one, uh, issue in pregnancy. Not, you know, preeclampsia, and not, you know, whatever, it’s perinatal depression [...] and we’re so not educated in it [...]” [6, RM]
Generally, there is a sense of insecurity in the quality of care PACPs can provide given the lack of integration of MH in their training and practices. As this FP said:

“[…] it isn’t as easy as calling one number [so] trying to navigate and see which is best for the woman in front of you is challenging.” [1, FP]

Thus, when discussing what would be advantageous to their efforts, many echoed this RM in needing a “multi-pronged approach” [9, RM] that would involve training PACPs, having specialists available to those who need them, and having relevant and affordable management resources for PP. Participants identified inter-professional support as necessary in this. Most considered MH an inter-disciplinary issue that requires collaborative approaches to care. This would address gaps in care integration and continuity. It would also lessen the burden of responsibility for their PP’s MH on them. As this RM expressed:

“[…] working with a group of other providers who have a varied level of experience, being able to plan and talk things through […] peer support is helpful. Feeling unafraid of addressing things that fall outside the realm of normal.” [9, RM]

Echoed by another:

“I’m biased towards liking to work in an interdisciplin ary team […] it really feels nice to be able to share the burden of more complex patients […] and not feel solely responsible for connecting this person to all the sorts of supports and resources that they might need.” [1, FP]

Many considered these necessary for “[…] customizing that person’s situation so that they have the best chance […]” [9, RM]. Participants emphasized their capacities to support PP’s “best chance” are currently underserved. Participants would like to see PP receive:
“[…] regular care by known care provider, access to information, referrals as appropriate, and baseline human needs taken care of. And ease of access to medication if required [whatever] ensures her stability of mental health.” [9, RM]

This includes accessibility to and “[…] awareness of resources.” [1, FP] That’s to say, they would appreciate supports where they are currently compensating and generally perceive having limited capacities to address concerns.

Certainly, all participants lamented how difficult it is to support PP experiencing AD, reflecting on how the resources they possess, are aware of, and can refer to are limited. So, when reflecting on what could help, many spoke of how they would benefit from a resource hub to refer to. As this FP explained, having “[…] a go-to page [that] would be like: here are all the lists of the resources for this patient […]” [3, FP] would overcome the time and awareness barriers they currently face in finding supports appropriate for PP. This is unsurprising given how much physicians rely on their EMR to guide them toward supports (3.2.2.1.1.).

Cumulatively, PACPs’ ability to give PP experiencing AD during pregnancy their due diligence is limited by their training, professional demands, care continuity, and availability and awareness of supports (PACPs and PPs alike). Our discussions focused on gaps and barriers as they were the overwhelming majority of what they experienced every day in trying to integrate MH in their practices and address AD with PP. In the participants’ opinion, system support is necessary to minimize avoidable adverse pregnancy outcomes associated with AD.

3.2.6 Attitudes and perspectives towards knowledge implementation in primary antenatal care settings

The siloed healthcare system makes things difficult to communicate within and implement throughout. Not only do our three PACP groups differ in training and practice, but –
as discussed above – mental health is perceived to be extra (i.e. not integrated and thus takes more time). The barriers participants reported facing in addressing AD during pregnancy introduce important considerations for knowledge translation, mobilization, and implementation in their care contexts. Participants reported receiving new knowledge constantly, but not having the time to appraise what is “[…] good enough to make a change?” [8, RM]. This impacts how responsive they can be to the new knowledge. Most agreed it is not enough to put evidence out there for PACPs (and PP) to act on. As illustrated by this ObGyn:

“I mean, I read ten million things a day and I’m sure you don’t read enough things to be up-to-date on everything […] I’m sure I’m not up-to-date on other things [...]” [11, ObGyn]

And RM:

“[…] there is a whole bunch of information and trying to suss out what is relevant and not.” [8, RM] adding: “[…] part of it is that there is a huge amount of new information and… as a clinician you just can’t read everything [and] then you have to appraise it […]” [8, RM]

The overwhelming amount of knowledge participants reportedly receive compromises their awareness of new strategies that could alleviate the worries they experience in relation to the barriers and gaps in addressing AD. This contributes to their knowledge deficits, rather than easing them.

For knowledge to be actionable, it must be translated to the end-users’ needs and account for existing barriers. As this FP said:

“[…] if you are going to try to get [PACPs] to change their practice, just making that low-barrier and fit-in to their, to mixed schedules […]” [1, FP]
In our discussions regarding how PACPs address AD, time was identified as an omnipresent determinant. Perhaps unsurprisingly, it is also a determinant of implementation. Participants repeatedly described perinatal care as demanding, and time as scant:

“I mean... people... Doctors are, in general, Doctors and Midwives, it’s like you’re busy and you’re always... you’re always busy and it always feels like you’re pressed for time.”

[4, FP]

So, as this ObGyn stated “Time and efficiency.” [10, ObGyn] are important considerations for knowledge implementation as new recommendations compete with clinical experience and professional demands (time):

“[…] as a practitioner you already are into your habits and it’s so demanding […] a lot of us do not necessarily try to go out of the boundaries to try to implement something else.” [6, RM]

Indeed, “Like, finding time to do that […]” [12, ObGyn] is a challenge that deters many from trying something new, and maintains their reliance on what they know. Thus, when asked what would be necessary to support their capacity to integrate new strategies to address AD during pregnancy, many echoed:

“It’s complicated. This is all complicated.” [10, ObGyn]

All participants described how it’s complicated in ways that elucidated paradoxical attitudes toward new knowledge and strategies to address mental health during pregnancy: most of those interviewed noted the necessity for changes, but skepticism toward implementing recommendations (favouring their ways). When participants reflected on the complexity in how to support PACPs’ knowledge needs in addressing AD during pregnancy, most emphasized they need help. As this FP said:
“I think everybody will want to help people with mental health concerns, but like pragmatic pieces of it can be difficult.” [2, FP]

Participants, feeling overburdened by having to make do, noted how resolving these “pieces” is:

“[…] something that’s really systemic, [and] systems are so slow. And our colleges have different requirements! […] It can be challenging sometimes. Like, all the time.” [8, RM]

So, again, they compensate and make do as they await support. In general, participants didn’t perceive themselves to have much capacity to address AD during pregnancy nor consider new ways of doing so. They reported needing system support in both to “make it easier” [8 RM] and motivate changes.

3.2.6.1 “Make it easier” to implement new knowledge, care recommendations and strategies in primary antenatal care settings

Participants reported feeling short on time to investigate, explore, consider, and implement new knowledge, care recommendations and strategies in their practices. They emphasized how “[...] not [having] enough time. So, full clinics [...] those time, time pressures.” [7, RM] hinders their ability to do anything different from what they currently rely on. To overcome the barriers that exist to integrating MH in their care settings, some participants offered insights to making implementation easier. To consider doing something new, most participants noted they need support in becoming aware of it, spending time on it (engagement), and feeling competent in it (mobilization). All FPs interviewed highlighted how awareness is integral to action; they need to

“[…] know about the option, understand why it’s important, really believe in it, and then be able to take it forward […] feel really supported and excited about it.” [4, FP]
Indeed, “[…] awareness is… huge.” [1, FP] and they “[…] need to know how to do it […]” [3, FP] because if “[…] people don’t know about the knowledge, it’s not easy to implement.” [4, FP] However, participants noted:

“[…] reaching people on the front-line is always a challenge.” [2, FP]

Thus, efforts need to be assertive and consistent:

“You have to push people, I think, a little bit more to hear the information is people deem it’s important.” [1, FP]

One way to overcome barriers to awareness – including time – requested by participants was to have the evidence appraised and made actionable for them, or as this ObGyn said:

“[…] there should be some means of, um, disseminating information from tertiary care centers where they, they’re you know, more involved in research […] that says: by the way, look at this that’s come out.” [12, ObGyn]

This strategy to make things easier was most often brought up by ObGyns, noting they would benefit from having “[…] somebody in a department […] part of their job/salary so that they can dedicate themselves to… collecting evidence-based medicine [and] able to disseminate that within their own hospital and integrating it within the hospital.” [12, ObGyn]

This demonstrates the perceived need among participants of minimizing their responsibility in addressing AD during pregnancy and in integrating MH in their care settings (mobilization). A few participants considered PP’s roles in motivating both, as “Educating patients and raising their expectations of the care they are provided is also effective as they will then ask.” [10, ObGyn] Indeed, one RM considered this “the biggest factor” in implementation, explaining:
“[…] if women are aware of it and it’s perceived to be of benefit to them, they will come and ask for it, and that will actually probably be the biggest factor. If we have women asking for it, then we will probably start offering it more.” [9, RM]

However, this does not ensure PACPs know how to do “it”. They need to feel prepared for when PP ask for it, and they need help getting there. To make implementation easier, participants noted the recommendations must facilitate their capacities to act on them. As this FP stated:

“[…] I find a huge barrier in, in implementing new things is I feel I don’t have the skills, or I don’t have the knowledge. So, I need to learn how. Uh, I need to be, I need to know everything that is available.” [3, FP]

Given professional demands PACPs report experiencing, it’s not enough to have the knowledge disseminated to them, it needs to be made actionable (for them). For it to be, it needs to be easy and efficient – accounting for professional demands, diversity, and time constraints – because PACPs have a lot going on. So, we need to consider “How easy it is to transition from the way that [they]’re currently providing to something new and how willing people are to change.” [4, FP] and find ways to facilitate that. It’s important to PACPs they’re ensured “that it works” [8, RM] as supported by evidence that is “[…] thoroughly researched, well-presented, accessible, meaningful, and demonstrate change and improved outcomes […]” [9, RM]. In summary, making implementation easy requires: (1) making PACPs aware of what needs changing, why change is necessary, and how to go about it; (2) recognizing barriers in their care contexts and offering options to overcome them; (3) making PACPs feel supported in their efforts toward change.
3.2.6.2 Motivations to change

As those on the frontlines of care, all participants recognized the instrumental role they play in shaping health outcomes. Throughout our discussions it became increasingly apparent that to motivate implementation among PACPs, recommendations must appeal to their needs and values. Participants described their needs in response to the gaps and barriers they experienced in addressing AD during pregnancy and knowledge implementation, and their values relative to the worries they were burdened with in doing so. Their motivations to make changes most often aligned with their need to increase PACP capacity to address AD, and value of supporting good health outcomes. As this ObGyn stated:

“A motivating factor would probably be professional satisfaction... for it. Knowing that, that what you do is going to uh... better the outcomes for your patients and your patient care.” [12, ObGyn]

As such, participants emphasized needing to be assured making changes to the care they deliver will be worth their time:

“if I’m going to change my practice [...] tell me it’s beneficial.” [11, ObGyn]

The relationships between PACPs’ time constraints and their reliance on clinical experience, expertise and intuition is something to account for when making recommendations. As this RM explained:

“[...] something that also happens as you become more experienced is you, you get kind of clinical intuition, clinical sense and you have clinical judgement... and sometimes that, you know, evidence doesn’t address that. [...] it’s not a factor that can be accounted for.” [9, RM]
In other words, to motivate PACPs to change what they’ve relied on until now, they must receive guidance (make it easier) and assurance that it’ll be worth their and PP’s time because—as this RM explained—they “[...] get stuck in their ways, and as a clinician, one can have sentinel experiences that will shape their practice regardless of the evidence.” [9, RM]. These are important insights for knowledge translation as they indicate that PACPs often distrust what isn’t part of their practice already.

“[...] medical professionals are really suspicious. They don’t trust anything until it’s been thoroughly validated and used and established [...]” [9, RM]

Especially when “[...] people have been doing things a way for a long time and sometimes that can be hard to change.” [2, FP] because they are certain of what health outcomes look like using these approaches. Thus, to encourage implementation, strategies (e.g. recommendations) must emphasize worth in terms of time spent to improve outcomes (value) supported by evidence (need). As this FP said:

“So, what would be a motivating factor for me? I think really seeing that it makes a – an impact with the patient and convincing me of that [...]” [1, FP] re-iterating: “I have a lot of buy-in that it’s really like going to change the care of the woman or change people’s outcomes, that’s a big factor for me.” [1, FP]

Simply put, by this ObGyn:

“[...] physicians are more likely to do it if they think it’s good for their patients.” [10, ObGyn]

One FP offered examples of what “good for their patients” looks like, stating:

“[...] ‘women are happier!’, like: ‘they have less complications in their pregnancy’ there’s so many different outcomes that it effects. Um, highlight that.” [1, FP]
Participants considered centering PP perspectives “Super important” [2, FP & 6, RM] in informing what is “good for their patients”. PP perspectives were valued greatly among all PACPs interviewed and considered a motivating factor in considering new knowledge to inform their practices. Particularly as “[…] it’s their experience that we’re trying to change to some degree.” [2, FP] and in this FP’s words:

“I think so much of healthcare has been done without the patient’s actual voice […]” [1, FP]

Given their value of improved health outcomes, including patient perspectives in evidence can lend further credibility to evidence because – as this FP said: “[…] obviously their voice is probably the most important because they are the ones that are going through the issues […]” [5, FP] Additionally, given participants’ worries regarding where PP get their self-management information some considered the importance of having insight to what resources they rely on. As this ObGyn said:

“[…] I think it would be very useful to… to know what the patients find useful.” [12, ObGyn]

Participants’ value of improved outcomes and their need for evidence must be addressed to motivate change. Additionally, their preoccupation with time must be addressed. As such, participants reported incentivization being a strong motivator. The two main forms of incentives discussed were financial and accredited professional development. As this FP explained:

“[…] like incentive – maybe have, either giving me CME credits for learning about this, or making it free, or even compensating the physicians if they give their time to learning about this thing.” [3, FP]
And creating a billing structure that “[…] compensate[s] the Doctor for spending time […]” [3, FP] as this could overcome obstacles to knowledge seeking and integration efforts.

Throughout the interviews, it became apparent that for knowledge implementation in perinatal care, we need to be aware of PACPs’ values and needs relative to the persistent gaps and barriers discussed above (all sections). In general, PACPs interviewed expressed the value of person-centered care, awareness and accessibility of pregnancy-specific mental health supports, and strengths-based approaches to AD prevention, promotion, and management (e.g. empowerment). This means that to motivate PACPs to implement new knowledge, recommendations must align with their values (e.g. care quality and patient outcomes) and address their needs (e.g. time and evidence). This would make recommendations more appealing and perceivably actionable.

Ideally, we need what this FP asserted:

“[to] build a government that supports mental health care” [1, FP]

This is a lofty goal! In the meantime, PACPs need support in addressing AD during pregnancy with their PP. This Interpretive Description of PACP experiences has presented new knowledge that can inform how AD are addressed during pregnancy. The findings described herein indicate this issue needs system-level attention and support. This is explored further in the Discussion where opportunities for action are identified and recommendations are made.
Chapter 4: Discussion

This chapter expands on the knowledge constructed throughout and presented within this study. It revisits the knowledge base to substantiate the trustworthiness of results and elaborates recommendations to promote transformations in perinatal care toward mental health integration. The Interpretive Description of PACP attitudes and perspectives toward AD during pregnancy, how it’s addressed, and how pregnancy health outcomes can be better supported detailed in this Thesis offers new knowledge to leverage and generate changes at every level of care priority-setting (research, practice, program, and policy). Specifically, for the perinatal care community, this research aimed to generate new knowledge, describing current practices to inform the services and systems that respond to the needs of PP experiencing AD. In this way, this project sought to garner a deeper understanding of how things are (from those on the frontlines of care) to inform what could be improved in perinatal mental health (PP) and perinatal health care (PACPs). The KTA intention of this study aimed to provide PACPs with strategies and resources to support their care of PP experiencing AD. Some recommendations are made that respond to the identified need for systems support.

In this section, I reflect on how this study adds to our knowledge regarding the identification and management of AD during pregnancy and PACPs’ knowledge needs in both, as well as what it can inform (KTA recommendations).

To our knowledge, this is the first study of its kind completed within Greater Vancouver. Local investigators including Dr. H Bayrampour (Co-Supervisor), Dr. N Fairbrother, and collaborators have established a rich knowledge base regarding the prevalence and incidence of AD in pregnancy (Bayrampour et al., 2015, 2016; Fairbrother et al., 2015, 2016) as well as screening practice acceptability among patients and care providers (Bayrampour et al., 2017,
2018; Fairbrother et al., 2019). However, this is the first to involve all three antenatal provider
groups in a qualitative study exploring their perspectives. As such, it provides new knowledge on
how to close the gap between what is known and what is being done.

4.1 Identifying anxiety and depression during pregnancy

Whether pre-existing, recurring, or emerging during pregnancy, participants regarded AD
to be relatively prevalent in their patient populations. PACPs described the strategies they rely on
to identify these cases. Although the Edinburg Postnatal Depression Scale (EPDS) is a
standardized screening tool that has been integrated in British Columbia (BC) antenatal care
forms (BC Reproductive Mental Health Program & Perinatal Services BC, 2014), most of the
PACPs interviewed relied on it sparingly as compared to other methods of detection. This is
consistent with previous investigations (Bayrampour et al., 2018; Coburn et al., 2018;
Fairbrother et al., 2019; Price et al., 2012; Psaros et al., 2010).

With respect to the EPDS, I align with the participants of this study. Per Interpretive
Description practices, I accounted for biases by maintaining reflexive memos and returning to
participants with provisional findings (member-checking). When I began this investigation, I
perceived the EPDS to be a valuable proponent of identification in the interest of management.
That’s to say, I viewed the EPDS as a necessary first step toward supporting PP experiencing
AD. To this end, in my initial research planning my objectives were (1) to understand current
practices; (2) to inform strategies that would engage users (PACPs), promote the value of
identifying (and supporting) cases of anxiety and/or depression during pregnancy to them, and
(3) provide stakeholders the opportunity to engage in the development, delivery and refinement
of the resultant strategies (appendix A). While the development of a knowledge translation
strategy was outside the scope of this study, my approach to inquiry was guided by this initial
objective. It was during that time that I made some assumptions that participants dispelled throughout interviews, including: if Perinatal Services BC had integrated the EPDS in perinatal care forms, it was a reliable tool. Based on participant’s descriptions of their experiences using the EPDS, I now perceive there to be a need to assess its utility in identifying AD concerns during pregnancy. It is necessary to discover effective ways to identify AD during pregnancy so that (1) it is more readily addressed; (2) there is greater understanding of perinatal AD. While the latter is very important, this study focuses on the former. Still, it is important to note that without effective means of identification, understanding of anxiety and depression during pregnancy will be continuously compromised, undermining their recognizability in clinical settings and leading to poor perinatal health outcomes (Misri et al., 2015).

While the EPDS is the most used screening tool for postpartum depression, it is by no means the gold standard of identification. The EPDS was originally developed to screen for postpartum depression, but has been assessed for use throughout the perinatal period as well as beyond depression to include anxiety (Fairbrother et al., 2019). Still, the accuracy of the EPDS is “far from established” (Fairbrother et al., 2019). Recently, Fairbroth et al. (2019) examined the accuracy of scales used to screen for perinatal anxiety disorders, including the EPDS, its anxiety subscale (EPDS-3A), and the Generalized Anxiety Disorder 7 and 2-item Scales (GAD-7 and GAD-2) alongside a clinically derived alternative; the Anxiety Disorder – 13 (AD-13) with 310 women living in British Columbia (Fairbrother et al., 2019). They concluded that neither the EPDS/EPDS 3-A, nor the GAD-7/GAD-2 should be recommended for widespread use as perinatal anxiety disorder screening tools (Fairbrother et al., 2019). The AD-13 performed better on all accounts (specificity, sensitivity, and predictive values) and was recommended as an effective alternative (Fairbrother et al., 2019). Its out-performance of the tool currently
recommended suggests “we can do far better than the established screening instruments allow” (Fairbrother et al., 2019). This is significant given how anxiety is more prevalent than depression, yet the EPDS is the recommended screening tool (BC Reproductive Mental Health Program & Perinatal Services BC, 2014).

Although pregnancy has been identified as a time of great mood instability and increased risk of mood disorders (Kruper & Wichman, 2017), the EPDS assesses mood retrospectively, assuming the respondent’s mood has been stable over the course of a week (Bowen et al., 2012). This is notable given how a characteristic of mood disorders is fluctuations in mood (i.e. mood instability). Further, the periods of highest levels of fluctuation (between irritable, euphoric, and depressed moods) occur early in pregnancy and before delivery (Bowen et al., 2012) yet the EPDS is recommended to be administered once at 28-32 weeks gestation (early in 3rd trimester) and postpartum.

In separate reviews of studies validating the EPDS for ante- and post-partum use, Kozinszky & Dudas (2015) and Gibson et al. (2009) found the accuracy of the EPDS is highly variable and dependent on clinical setting, timing (i.e. antepartum or postpartum), approach to administration (e.g. higher acceptability by women if given sympathetically), language and culture (Gibson et al., 2009; Kozinszky & Dudas, 2015). Gibson et al. (2009) noted how the latter is significant given that the EPDS was developed in the West, so it cannot accurately detect AD in other cultural settings nor in PP with different ways of meaning-making rooted in culture (Gibson et al., 2009). The variability in acceptability, affect, context, and timing impacts the measurability of the accuracy, reliability, and validity of the EPDS. These factors were continuously raised by participants as reasons why their EPDS compliance is low. While this undermines the reliability of the EPDS, it also emphasizes the need for integrated care in
perinatal settings as pregnancy is a key transitional phase (i.e. many changes) that offers opportunities for psychosocial intervention (Hoffman & Wisner, 2017; Kruper & Wichman, 2017; Selix et al., 2017). The participants of this study echoed these sentiments, valuing interdisciplinary care teams and collaborative approaches to care. Generally, participants expressed distrust of standardized screening tools (the EPDS in particular), favouring their clinical expertise and intuition. Some of those who used the EPDS episodically or selectively explained they often did so to confirm their clinical intuition. Others did so to catalyze conversations about mental health. Ultimately, they seemingly gauged the perceived appropriateness of the EPDS with any given PP relative to whatever they felt most comfortable with (perceived to be safe and efficient) and tailored their approaches accordingly. Herein lies an opportunity to adapt recommendations for the use of the EPDS. The development of an interpersonal user guide to the EPDS could reinforce the strengths in dyadic care relationships (i.e. rapport, trust). De-formalizing the process of administering this self-assessment tool could minimize perceived harms such as stigmatization, triggering and alienation. This strengths-based and appreciative approach to identification that centers dyads could nurture emotional literacy, mitigate fears of disclosure, increase the personalization of care, and seamlessly begin conversations about the availability of and pathways toward support. This could overcome psychosocial (e.g. stigma), interpersonal (e.g. alienation), systemic (e.g. clinical practice), and structural (e.g. access to supports) barriers in addressing AD during pregnancy. Further research and assessment are needed to determine the feasibility of such a screening practice. Promisingly, the use of concurrent risk identification (e.g. clinical intuition) and symptom profile measures (e.g. EPDS) has been recommended to identify PP at risk of and experiencing mental health concerns (Austin et al. 2018). Approaching identification in this way can mitigate the
“confounding effects of referral pathways and uptake on clinical outcomes” (Austin et al. 2018) and have greater impact on health outcomes by addressing PACPs’ worries about alienating PP and relying on their strengths to facilitate the identification through management of AD during pregnancy.

In addition to skepticism regarding the relevance of screening tools, barriers to identification described by participants reflected the evidence base, including how professional demands and time pressures (Bayrampour et al., 2018; Kruper & Wichman, 2017; Price et al., 2012; Psaros et al., 2010), as well as hesitance regarding their capacities to manage (Ford et al., 2017; Price et al., 2012) lead to the prioritization of physiological medical care (Kruper & Wichman, 2017). Altogether, these manifested an omnipresent worry participants referred to as the “then what?” associated with being less likely to screen for AD during pregnancy, as the lack of clarity regarding next steps made screening feel unnecessarily harmful. This does not imply they avoid identifying AD. Rather, it means that without clear pathways to supports, they perceive that the undertaking of standardized screening with PP exacerbates mental ill-being (i.e. triggering). This is also corroborated by the evidence base. For instance, failures to connect PP with mental health care services after screening has been described by Kim et al. (2010) as a “supply side flaw of the healthcare system” (Kim et al., 2010) that obstructs access to needed care. This is a significant threat to perinatal health equity.

While there are apparent deficiencies in the status quo of pathways toward AD identification through to management during the perinatal period, in noting what they rely on, participants identified existing strengths that could buttress responsiveness to PP’s mental health needs. These included their dyadic relationships with PP and the trust, intuition, and experiential expertise (from both in the dyad) integral to efficient, effective, and relevant care.
Irrespective of provider group (ObGyn, FP, RM), participants described approaching the subject of AD with PP when they saw signs for concern (e.g. changes in function), relying on their clinical expertise and intuition to flag them. The trust and rapport fostered within their PACP-PP dyads were considered essential to the identification and management of AD during pregnancy. These relationships afford PACPs insights to PPs’ needs and the cues to tailor accordingly for relevance. The development of a relational guide to be used concurrently with screening tools could emphasize these strengths, minimize fears of isolating PP, and improve AD identification.

4.2 Managing anxiety and depression during pregnancy

This study revealed that the most prevalent barriers to PACPs addressing AD with their PP are the lack of resources, including time, training, and external supports (such as affordable counselling). Participants explained their capacity to help PP experiencing AD is greatly undermined by gaps in their training, restrictions on their time (professional demands), and a perceived lack of supports to rely on and/or refer to. Subsequently, PACPs feel under-resourced and over-burdened. A few are so disillusioned with the state of how things are that when asked about existing facilitators to addressing AD, they replied there are none. The one pregnancy-specific mental health resource that exists was considered largely unreliable. Reproductive Mental Health (RMH) provides free mental health to people throughout the reproductive lifespan (from first menstruation to menopause). As the only free mental health support for people with uteruses in their reproductive years, it is understandably overburdened. The wait times to access RMH – unless an acute case – can be months long. With a matter as time sensitive as pregnancy, such wait times render the service undependable. Interestingly, at least one ObGyn and FP
mentioned referring PP to RMs. Midwives (RMs) have longer clinic visits (~45 minutes per visit versus 5-10 minutes among ObGyns and FPs) which allow more space and time for relationship-building and counselling (normalizing AD, empowering PP, and offering recommendations). Interestingly, and counter to participant reflections, a review by Bayrampour et al. suggested that RMs are less prepared to address perinatal mental health concerns than other providers (Bayrampour et al., 2018). That said, no Canadian studies were included in the review (Bayrampour et al., 2018).

In this study, all participants lamented not having the capacity to address mental health in their care settings. In 2008, the Ministry of Health recommended providing training for health professionals on childbirth related mental health issues to increase detection rates and improve patient care, from prevention to management. Kruper & Wichman (2017) asserted this education should be extended to all medical staff who have close contact with PP (to create safe, judgement-free spaces) (Kruper & Wichman, 2017). Indeed, in 2006, the BC Reproductive Mental Health team reported widespread concern among all care providers, encompassing PACPs, public health nurses, mental health specialists, and so on about our current system’s capacity to respond to PP experiencing mental health concerns (BC Reproductive Mental Health Program, 2006). The findings of this study affirm their report by revealing that care providers feel under-informed and under-resourced in supporting PP experiencing AD. Some participants noted how they would benefit from interdisciplinary and peer support to bridge these gaps in care. Similarly, Gerdes et al. (2001), Price et al. (2012), and Selix et al. (2017) have called for collaboration between primary care providers and mental health care providers in the interest of bolstering provider readiness to identify and confidence in managing concerns (Gerdes et al., 2001; Price et al., 2012; Selix et al., 2017).
4.3 Knowledge-to-action

With growing emphasis on evidence-based, cost-effective, and accountable health care, knowledge-to-action (KTA) has become as an integral component of the research process to ensure implementation – making the knowledge actionable. In working towards establishing KTA as a collaborative process to optimize action, we not only need to consider the contexts within which it will be used, but also who will be involved: the human element. All those involved will have different interests, different levels of access to resources, and different availabilities to dedicate time towards KT and implementation (action). As such, we need to think about KTA as social processes whereby relationships are developed in the interest of actionability, integration, and sustainability. In the case of addressing AD during pregnancy, much of the KTA has been oriented toward PP (e.g. self-management) and/or PACPs (e.g. screening recommendations). The current focus on the individual level (PPs and PACPs) does not account for how people make decisions (e.g. value-based intuition often deflates evidence-based recommendations) and how their agency to act on recommendations is restricted (e.g. time, money). The focus on the individual erases much of the complexity that exists in this issue. Without accounting for systemic constraints (at policy and practice levels), recommendations fall short of facilitating implementation and integration. One must consider how the KTA they deliver is in competition with other sources of information, and how power dynamics, interests, institutional priorities, and resources impact the translation of knowledge to action. Simply putting the knowledge “out there” does not guarantee its use. This was illustrated in participants’ accounts of receiving new knowledge constantly, but not having the time to explore, appraise, and act on new knowledge, care recommendations, and strategies in their practice and clinical
settings. This also reportedly undermined their awareness of what is available to supplement their efforts in addressing AD.

Awareness was a significant requirement for PACPs to act on what’s available to them and their PP, as well as what else they could be doing. However, participants made a distinction between being made aware and making it easy to implement (because dissemination does not predict action). Indeed, many resources have not addressed the evidence that indicates how a perceived lack of time is a deterrent to action (use/implementation). For example, the guides produced by The BC Reproductive Mental Health Program for coping with anxiety and depression during pregnancy and following birth, are 175 pages on average (BC Reproductive Mental Health Program, n.d., 2006). These guides are aimed at care providers and PP alike. Knowing how neither of these populations perceive having time to spend on appraising mental health supports, these resources miss the mark regarding acceptability (KTA). Reading these documents can feel overwhelming and burdensome. Indeed, women have been found to feel overwhelmed with information, especially since there is no time for discussion and informed decision-making with their PACPs (Downe et al., 2016). Further, the evidence of this study suggests that PACPs don’t have the time to comb through a ~175 page document and appraise worthiness of implementation of recommended actions.

PACPs’ professional demands and time constraints shape their knowledge needs and implementation contexts. For PACPs to consider changing their current practices, they must have the anxieties they have regarding changing their practices addressed. Along with awareness, assurance the recommendations are good enough and their efforts are worth it are necessary. Proof of demonstrable impact on PP health outcomes (backed by evidence) and incentivization to spend time on it (e.g. CME credits) commonly fulfilled these motivating values (good enough
and worth it, respectively). Evidence of the need for change from patients was also highly valued with participants noting that PP (or parents who experienced AD in their pregnancies) are the experts in what does or does not help. However, such motivations to change (aligned with PACP needs and values) require facilitation; barriers must be addressed.

To address the time barriers that exist in KTA, participants recommended having people in paid positions who do this work for them. In essence, knowledge translators; people who appraise evidence on their behalf and direct them toward the actions necessary to implement it. PACPs need to feel supported in their efforts (and capacities) toward addressing AD during pregnancy, especially if they need to consider trying something new.

Cumulatively, participants described a multilevel phenomenon that requires intervention at the PP (and family), provider (not exclusively PACPs), organization, system, and social levels. They reflected on their current practices as lacking the knowledge to increase the detection and management of AD. Many emphasized the need for mental health integration in perinatal health care. This would alleviate the burdensome responsibility they feel for their PP’s mental health (detection, promotion, management, and the appropriate supports therein). To create demand for existing structures to change in favour of integrating mental health into perinatal care, we need to think about who has the power to stimulate adaptations by the healthcare system in how it supports mental health. While I entered this project assuming PACPs had this power, participants identified that the changes need to happen up-stream where the money comes from. Participants reported doing their best in a system that does not fund mental health care and does not support their integration of mental health in their care settings (e.g. funding mental health training for PACPs). To this end, it will be important to motivate KTA by producing bite-sized
dissemination strategies that target decision-makers, including Perinatal Services BC – the group that provides leadership, support, and coordination perinatal services in British Columbia.

4.4 Recommendations

According to the Mental Health Commission of Canada, healthcare for those living with mental health challenges is one of the most complex systems to manage in healthcare (Mental Health Commission of Canada, 2014a). Indeed, access to and effective coordination of care that requires services across multiple provider groups is the most difficult for the system to manage (Ministry of Health, 2015). Challenging and changing established care practices requires collaboration and action at the patient (PP agency), dyadic (PP-PACP relationships), organizational (including hospitals), and system (health authorities and the Ministry) levels. The Interpretive Description of PACP perspectives detailed in this Thesis offers new knowledge to leverage and generate change at every level of care priority setting.

The participants of this study insisted that funding translates to care priority. As such, this study recommends funding be allocated toward integrating mental health in perinatal care provider training, care settings, and our healthcare system at large. This involves: (1) funding mental health care; (2) making mental health care resources available and accessible (i.e. affordable, appropriate, and relevant); (3) integrating mental health in perinatal care research, training and clinical settings.

4.4.1 Funding mental health care

Two primary models exist for care provider payment: fee for service (ObGyns and FPs), and alternative payments (RM). The majority of payments are issued through the former (70%) (Auditor General of British Columbia, 2017). As explained by the ObGyns and FPs in this study, fee for service severely restricts time spent with patients. This shapes the quality of care they can
provide PP. RMs on the other hand, are paid by trimester and can spend almost ten times the amount of time with their PP than ObGyns and FPs (i.e. 45-60 minute appointments as compared to 5-10 minute appointments). Adaptations to fee for service billing practices are necessary to improve the quality of care PACPs can provide by allowing more time to address AD with PP.

At least one FP mentioned how they have a billing structure in place for those who have completed Continuing Medical Education on providing Cognitive Behavioural Therapy. This structure allows them to bill for up to 20 minutes spent counselling patients. Given their professional demands and time constraints, we can assume only a select few FPs have completed this training. It was unclear whether any of the FPs interviewed for this study had completed it as I did not ask directly.

In 2019, The Shared Care Committee, a partnership of the Doctors of BC and the BC government produced a technical guide for billing in maternity care (Momtazian et al., 2019). It confirms that only FPs can bill a mental health planning and management fee “to a maximum of 4 counselling codes/yr/patient.” (Momtazian et al., 2019) That’s to say, FPs can only be compensated for four counselling sessions per year per PP. This presents a hindrance to continuity of care. In a 2016 report by the Auditor General of BC on tertiary mental health and substance use services, it was asserted that the Ministry of Health and health authorities are “not doing enough” to ensure people are getting the help they need (Auditor General of British Columbia, 2016). This rings true in this project. Our Ministry and health authorities have the responsibility to make mental health services available and accessible; from prevention to management (Auditor General of British Columbia, 2016). Currently, our health authorities only allocate 7% of funding toward mental health and substance use. The Canadian Association of Mental Health has developed a Mental Health Strategy for Canada that recommends raising the
proportion of funds allocated to mental health to 9% by 2022 (Mental Health Commission of Canada, 2012). Given how decisions are based on previous years of funding, it is clear that these past choices have left our healthcare system “failing to provide British Columbians with timely access to quality services” (Ministry of Finance, 2019). This is in part due to the undervaluing and underfunding of primary healthcare in Canada (Hutchison et al., 2011). This was illustrated in participants’ reports of feeling overburdened and under-supported. As the main pillar in providing and supporting high-functioning, quality healthcare, primary healthcare is integral to health outcomes. This is not structurally sound; the weight must be distributed in the interest of improved outcomes.

In order to minimize the burdens associated with AD during pregnancy on PP, their families, and PACPs, our systems need to challenge how spending has been allocated between this issue and other competing public health demands. We need to show our commitment to transforming health outcomes and supporting BC’s families by reimagining how we fund primary healthcare and mental health. There is much evidence to substantiate how promotion, prevention and early intervention show positive investment on returns (Mental Health Commission of Canada, 2014b).

4.4.2 Improving access to pregnancy-specific mental health resources

A notable worry among participants was a perceived scarcity of pregnancy-specific mental health resources. Often worried about the “then what?”, they reported grappling with uncertainty and disproportionate responsibility in how to support PP experiencing AD. The integration of mental health and interdisciplinary care teams in perinatal settings were identified as priorities.
The World Health Organization (WHO) and the United Nations Population Fund have jointly decreed there can be “no health without mental health” and have initiated a program to integrate mental health in existing perinatal care policies, plans, and activities (World Health Organization, 2008). According to the WHO’s Thinking Healthy Manual (2015), psychosocial interventions should be the first-line of management for AD during pregnancy (World Health Organization, 2015). In 2018, the Mental Health Gap Action Programme (mhGAP) was initiated to support the detection and management of mental health concerns by non-specialists, including primary care providers (World Health Organization, 2016). The program recommends care providers work together with specialists and families to support PP experiencing mental health concerns and modify treatment plans for special populations (World Health Organization, 2016). This involved fostering “strong links with employment, education, social services (including housing) and other relevant sectors” as mental health challenges interfere in people’s ability to function in families, work, and in society at large (World Health Organization, 2016). It is important to note how this strategy recognizes the importance of lessening PP’s loads as they transition through growing their families. How to inform the integration of such approaches in primary perinatal care settings needs to be informed by further research that accounts for PACP knowledge needs and the barriers they encounter in addressing them.

Inter-disciplinary, inter-professional, and inter-agency collaboration has been identified as necessary in the design and delivery of perinatal mental health services (BC Reproductive Mental Health Program, 2006). Based on the value participants placed on the patient voice and delivering person-centered care (tailored for relevance), I would add inter-social collaboration is also necessary. Most of the recommendations made, including locally, focus on self-management. This strains PP who are already feeling stressed and overwhelmed as well as
PACPs who are implicitly responsible for educating PP. The inclusion of our communities in discussions regarding priority-setting is important. For instance, Fairborther et al. (2016)’s recommendations to respond to AD during pregnancy included educating PP, their families, and PACPs regarding AD, screening, and improving access to psychosocial treatment (Fairbrother et al., 2016). Absolutely, all three recommendations speak to the importance of normalizing fluctuations in mood during pregnancy, identifying and supporting cases of AD, and addressing the psychosocial complexity of AD experiences (respectively) in the interest of improving health outcomes. But what does this mean insofar as next steps?

The Auditor General has recommended the Ministry of Health and health authorities collaborate toward creating new approaches to waitlist tracking, including consistent documentation of acceptance, prioritization, and declination practices (Auditor General of British Columbia, 2016). In 2006, the BC Reproductive Mental Health program proposed a framework built on four pillars to improve perinatal services for mental health. They included: education and prevention, screening and diagnosis, treatment and self-management, and coping and support networks (BC Reproductive Mental Health Program, 2006). Additionally, they pointed to the health authorities’ leadership roles in the planning, implementing, and monitoring of a person-centered, collaborative, and effective continuum of services (BC Reproductive Mental Health Program, 2006). Given their role in the allocation of funds toward mental health, engaging our health authorities is necessary in making mental health resources accessible. The allocation of funding toward research, training, program and policy development can increase the availability, affordability, relevance, appropriateness and acceptability of mental health supports. Certainly, mental health needs to be established as a priority and integrated in funding decision-making.
4.4.3 Integrating mental health in perinatal care

There is mounting evidence that supports the assertions made herein regarding the necessity of integrated care in addressing AD during pregnancy. What this looks like has been explored differently throughout the evidence base. Care programs that promote caring for body and mind, including mindfulness therapies have been found to have promising value in improving perinatal mental health outcomes (Lavender et al., 2016; Townshend et al., 2018). In their 2018 article, Townshend et al. assessed the effectiveness of the Caring for Body and Mind in Pregnancy (CBMP) in an Australian sample of 109 pregnant women at risk of perinatal anxiety, depression, and stress. They found that at the end of their 8-week intervention, the CBMP “significantly reduced perinatal depression, anxiety and stress” (Townshend et al., 2018). This was attributed to how mindfulness promotes self-compassion. Lavender et al. attributed the success of Mindfulness interventions to altering thought patterns, modifying behaviours, and developing awareness of coping mechanisms (Lavender et al., 2016). Indeed, the inclusion of psychosocial therapies such as Mindfulness in perinatal care has been attributed to sustained antenatal care service provision (Krupe & Wichman, 2017). This is noteworthy as PP experiencing mental health concerns have been found to internalize stigma and avoid disclosure and care. However, an intervention program that offers an interpretation of integrated care within a larger system that has yet to integrate mental health does not address the issues with responsibility of care. That’s to say, such an individual-based approach does not demand changes within the system to lessen the burden of responsibility of mental health on PP and PACPs.

In 2015, Yim et al. asserted that before we can achieve integrated healthcare, we must address how we do research. They noted that cross-disciplinary and integrated empirical studies are rare (Yim et al., 2015). Until there are more, our understandings of the biopsychosocial
complexity of AD during pregnancy will be limited, and in turn so too will the impact of our efforts. Similarly, the Mental Health Coalition of Canada has identified serious gaps in data that require a more collaborative approach to mental health data collection (Mental Health Commission of Canada, 2014). Just as healthcare is siloed, so is knowledge collection, production, and dissemination. This narrows our collective awareness of such issues.

Participants repeatedly noted the role of awareness in addressing AD during pregnancy; from how to identify and manage cases, to what resources are available to supplement their efforts therein. While the majority of participants perceived AD to be prevalent, the omnipresence of the “then what?” illustrates how perinatal mental health is under-researched, under-served, and under-acknowledged. Absolutely, there remains work to ensure mental health is integrated throughout knowledge, practice, policy, and funding siloes. For instance, in an 88-page report published by the Public Health Agency of Canada entitled “Perinatal Health Indicators for Canada 2017: a Report from the Canadian Perinatal Surveillance System”, mental health is mentioned once, as follows: “The most common diagnostic categories associated with these deaths in 2002/2003 to 2014/2015 were diseases of the circulatory system; other indirect causes (e.g., diseases of the digestive system, mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the puerperium); postpartum hemorrhage; hypertension complicating pregnancy, childbirth and the puerperium; and obstetric embolism” (Public Health Agency of Canada, 2017). This was published after Allen et al. (2010) asserted that the documentation of perinatal deaths in Canada demonstrated under-reporting on indirect causes including mental illness (Allen et al., 2010). When perinatal mental health isn’t represented in priority-setting and decision-making documents and spaces, it minimizes the urgency of the issue, trivializes avoidable adverse health outcomes, and erases the people (and
families; communities) experiencing them. More perinatal deaths are related to indirect causes (such as mental illness) than direct ones (such as cerebrovascular disorders) (Allen et al., 2010). Certainly, the results of this thesis argue perinatal mental health deserves greater attention than a mentioning within parentheses.

The BC Women’s Hospital could lead the way in integrating mental health in perinatal health, from research to practice. As an academic health services centre affiliated with the University of British Columbia, Simon Fraser University, the BC Centre of Excellence in Women’s Health, and the Women’s Health Research Institute, the hospital is in the unique position to set the tone in improving perinatal health outcomes. On average, 7100 babies are delivered annually at BC Women’s, 1000 of them are high risk, premature, and sick newborns (Provincial Health Services Authority, 2018). The hospital also offers specialized care for complex pregnancy conditions. As such, the hospital is well positioned to engage further in addressing how mental health impacts perinatal and infant health outcomes. This is reflected in their housing of the BC Reproductive Mental Health program. However, as evidenced by the long wait times that exist to access it, integration of mental health is lacking. In 2010, Kim et al. found that although most women accept referrals to mental health specialists (59%), only a fraction ultimately engage in treatment (27%). In other words, only a minority of PP experiencing AD during pregnancy receive the care they need (Kim et al., 2010). This is consistent with participants’ worries regarding PP’s access to mental health supports (and health outcomes).

Per the recommendation of some participants, education and training offer opportunities to integrate mental health in perinatal care. Currently, the University of British Columbia offers a free online Continuing Medical Education (CME) Course for all healthcare providers to learn
about perinatal AD (ubccpd.ca/course/perinata-depression). Given how the course content and materials exist, steps should be taken by the Faculty of Medicine and Department of Midwifery to integrate these teachings in their mandatory requirements. Integrating mental health education in curricula is preferable to offering CME courses as clinicians favour pursuing education in topics they are already familiar with and avoid knowledge areas they are deficient in (E. Straus et al., 2009).

Addressing AD during pregnancy offers opportunities to mitigate short- and long-term burdens of disease on PP, babies, families, PACPs, and our healthcare system. Unless they have a pre-existing chronic ailment, there is no other point in people’s lives in which they will have such constant contact with the healthcare system. The continuous nature of perinatal care presents ample opportunity for the detection and support of PP experiencing AD. Altogether, this thesis suggests that integrated approaches to perinatal health have benefits on perinatal mental health, PP’s self-reported health, and implies the minimization of mental health burdens on PP, their care providers, and the healthcare system. This can have lasting effects on PP, their families’, and their children’s’ health (Coburn et al., 2018), preventing: post-partum depression; preterm labour; low birth weight, and subsequent developmental challenges (Avni-Barron & Wiegartz, n.d.; Bayrampour et al., 2015; Dunkel Schetter & Tanner, 2012; D. Kingston et al., 2014; Skouteris et al., 2009).

4.5 Strengths and limitations

There are important distinctions between lay perspectives and professional understandings of mental health and perinatal care. These differences have immediate impacts on the quality of communication in building trusting patient-provider partnerships. Indeed, participants noted the value of patient voices in research and KTA development. For this reason,
a limitation of this study is the lack of involvement of PP. As a result, I cannot report on PP requirements to make addressing AD during pregnancy more accessible to them. That said, much of the evidence on perinatal mental health concerns centers the patient experience. Locally, researchers at the University of British Columbia such as Dr. H Bayrampour, Dr. N Fairbrother, and collaborators have generated much evidence on the subject (Bayrampour et al., 2016, 2017; Fairbrother et al., 2015, 2016, 2019). Thus, although not present in this study, PP perspectives are captured elsewhere. The PACPs in this study emphasized the value of the patient voice and its necessity in informing their practices. This is an important KTA consideration.

This study provides very little insight to how the identification and management of mental health concerns during pregnancy varies across and within the intersections of marginalized populations, including racial, ethnic (cultural), sexual, gender, and [dis]ability minorities. Unfortunately, this is commonplace in perinatal data collection and reporting in Canada. According to the WHO, Canadian national data (such as vital statistics and hospitalization databases) does not collect information on race and ethnicity, including Aboriginal status (Cook et al., 2017). Participants in this study reflected on how perceptions of mood and ability to be honest with care providers are culturally tied. What is considered normal mood/emotions, and the degree to which they receive messaging from their loved ones that their feelings are normal varies across families and shape PP’s likelihood to disclose and address their concerns with healthcare providers (D. E. Kingston et al., 2015). This study does not contribute to our knowledge about racial and ethnic disparities in perinatal mental health. Of the participants in this study, two FPs worked with racial and ethnic minorities: one completed a fellowship in a First Nations community, another works in a clinic that serves refugees and immigrants exclusively. The former noted the importance of pregnancy being a community
experience, involving familial supports in visits and care planning. The latter mentioned impacts of cultural gender roles, expectations, and an unfamiliarity with Canada’s systems in PP’s perinatal trajectories. Both reflected on the role of isolation in AD during pregnancy, as well as how we’re lacking strengths-based approaches to caring for these populations. Knowing how complex perinatal mental health is to address, perhaps the exclusion of minorities has been done in the interest of focusing investigations, or because they failed to undertake purposive sampling. This is a disservice to our knowledge and PP’s health outcomes. This study elucidates how addressing AD in pregnancy is a biopsychosocial issue. Without accounting for how marginalized identities shape people’s experiences, care will not be responsive to them and cross-generational health disparities will persist.

Similarly, this study does not contribute to understandings of addressing perinatal AD in rural and remote communities. Recruitment of participants outside of Greater Vancouver was beyond the scope of this study. While participants reflected on barriers to accessing mental health support during pregnancy in the urban metropolitan area of Vancouver, a few noted how it’s privileged as compared to rural, remote, and Indigenous communities. Over the last 20 years, BC has been experiencing a growing gap in access to perinatal care and services in rural, northern, and First Nations communities (Midwives Association of BC). This means families must travel far to receive the care they need, which is not a viable option for many. This is significant given that relative to northern, rural, and remote BC, Vancouver Coastal has low birth rates (indicating higher pregnancy rates and need for perinatal care in other areas of BC) (Giving Birth in BC, n.d.). Efforts are focusing on closing this gap. That said, general guiding documents by Perinatal Service BC lack specificity regarding service delivery and care access in rural and remote communities. This frames knowledge about care in rural, remote, and Indigenous
communities as specialized, maintaining gaps in understanding and responsiveness. As evidenced in participants’ descriptions of their experiences with PP experiencing AD in Vancouver, one size does not fit all. There are context specifics in rural, remote and Indigenous communities that require tailored recommendations for priority-setting in perinatal mental health support availability, accessibility and acceptability. This study is unable to contribute to the closing of the ongoing gaps in knowledge, service, and care impacting communities living outside of Vancouver. That said, it does emphasize the need for mental health integration in perinatal care, identifying healthcare priority-setting as a structural determinant of health equity. I perceive this to include critical reflection on intergenerational mental health considerations such as the colonial violence Canada’s systems are founded on. Future research would benefit from anti-oppressive frameworks in addressing perinatal mental health inequities among socially and geographically marginalized communities.

Methodologically, I have complied with established practices to build trustworthiness into my study (refer to 2.4). That said, my method of data collection may be perceived as biased; my interview approach may be seen as leading, particularly with my choice of case study. The case study I used (Appendix C) presents an antenatal woman whose husband contacts their PACP to report concerns regarding her mental health and everyday functioning. In it, perinatal AD screening tool scores indicate low risk of concern. However, the case study’s subject seems to be fairing otherwise. It focuses on deficits in the subject’s wellbeing and in clinical practices regarding the identification and management of perinatal AD. This is neither strengths-based nor appreciative, which may be perceived as leading toward what is not working rather than what is. That said, I approached the design of my interview guide after having steeped myself in the knowledge base regarding perinatal AD. Overwhelmingly – and perhaps predictively – it focuses
on what requires betterment in practices from research to clinical practice and policy priority-setting. In my search for case studies, I found cases were purposely deficit-focused as that is generally how health care and providers assess needs: in terms of what is wrong, and how do we fix it (Baškarada, 2014; Chokka, 2002; Gerhant et al., 2016; Greenhalgh, 2020). This was evident in how participants spoke of function (or lack thereof) when assessing PP’s mental health. Case studies are used to gain deep exploratory understandings of complex phenomena and have been identified as the preferred research method when how and why questions are posed (Baškarada, S. 2014). I chose the case study used because I perceived it could facilitate the exploration of “experiential transformation [of] tacit knowledge into explicit knowledge” (Baškarada, S. 2014) in how PACPs are addressing AD with PP, and why perinatal AD go unaddressed (leading to ongoing perinatal health inequities). The knowledge base regarding AD during pregnancy indicates that the case study used here is illustrative of the status quo, including common risk-factors and poor screening scale reliability. This approach to data collection lent itself well to triangulating the three PACP groups’ experiences with addressing AD in perinatal care settings and aligned well with my constructivist paradigm. Ultimately, the use of a case study demonstrating what works may have led the interviews differently. That said, given global trends in perinatal AD identification and management, I deemed the one used more illustrative of the status quo. Further, I perceive it to have led interviews in such a way that lent to my sympathizing with participants’ experiences and circumstances. As previously disclosed, I approached this study with assumptions, including that PACPs could catalyze transformations in perinatal health outcomes. Now I see they are overburdened, and that perinatal mental health is an issue that requires systems to lessen the burdens currently deferred onto PP and PACPs (and their dyads). While much of this study focuses on barriers to addressing AD during pregnancy, I
have also argued how these insights are valuable in informing strategies for perinatal health equity.

The sample size of this study can be considered another limitation. In positivist paradigms, sample size is important to establishing a credible and generalizable “truth”. The trustworthiness of my interpretation of these subjective truths has been established (view 2.4). Although this study included twelve participants (5 FPs, 4 RMs, 3 ObGyns), their descriptions of experiences in addressing AD during pregnancy reflect popular thinking within their disciplines at this point in time and offer valuable insights to where efforts ought to be focused. The implications of the findings invite us to think critically about where future research and care priority setting efforts should be directed (as detailed in recommendations). I have offered various angles from which to strategically address gaps in knowledge and care provision based on meaningful knowledge generated from interviews. The small sample size does not deny the relevance of these findings. Ultimately, the findings reflect how we still have room to grow in how we address AD during pregnancy.

Notwithstanding the limitations addressed, this study has notable strengths. The robust methodology used to interpret and describe the richness, breadth, and depth of the data collected via semi-structured interviews with local PACPs has been established. This is the first study to explore local PACPs’ perspectives regarding AD during pregnancy and how to address it. Specifically, it is the first to include all three PACP groups that BC’s PP can choose to be cared for throughout the perinatal period. Interestingly, although the three groups receive different training and work under varying mandates and structures, the overarching themes described in this Thesis illuminate how barriers to addressing AD during pregnancy are pervasive throughout perinatal care contexts and settings. Subsequently, this indicates a systems-level issue that
requires a multi-level, interdisciplinary, integrated approach to perinatal mental healthcare. The findings discussed herein have important implications for local practice priority setting and present opportunities to transform perinatal health in the interest of improving perinatal health outcomes.

4.6 Conclusions

This study has presented the Interpretive Description of barriers to addressing anxiety and depression during pregnancy from PACP perspectives and offered suggestions for promoting transformational changes to perinatal health care and outcomes. Perinatal care offers unique opportunities to lead the integration of mental health in our health systems. At every level, efforts need support (i.e. funding) toward raising awareness and filling gaps in training, care provision, and resources.

The World Health Organization, The Mental Health Coalition of Canada, The Centre for Addiction and Mental Health, and the British Columbia Auditor General have called for the allocation of resources toward mental health prevention, promotion, and management. To minimize the burdensome outcomes associated with poorly managed AD during pregnancy, we need to reassess priorities in how PACPs are trained, and how much money and time are spent on endorsing strengths-based approaches to person-centered care.

Further research is needed to understand how existing knowledge (including the new knowledge introduced in this study) can be effectively mobilized toward decision-making audiences. We need to create a demand for a new public narrative that demystifies AD during pregnancy to audiences at every level of this inter-social, inter-disciplinary, inter-professional, and inter-sectoral issue, and offers actionable recommendations to ensure PACPs feel capable in supporting PP in their pursuits of wellbeing.
Bibliography


https://www.bcauditor.com/sites/default/files/publications/reports/OAGBC_Mental_Health_Substance_Use_FINAL.pdf


https://doi.org/10.1016/j.infbeh.2012.07.017


https://doi.org/10.1016/j.midw.2015.02.009

BC Reproductive Mental Health Program. (n.d.). *Generalized Anxiety Disorder in the Perinatal Period.*


BC Reproductive Mental Health Program, & Perinatal Services BC. (2014). *Best Practice Guidelines for Mental Health Disorders in the Perinatal Period.*


https://doi.org/10.1111/j.1600-0447.2009.01363.x

*Giving Birth in BC.* (n.d.). Retrieved April 9, 2020, from

http://www.perinatalservicesbc.ca/health-info/labour-birth/giving-birth-in-bc


https://www150.statcan.gc.ca/n1/pub/11-630-x/11-630-x2014002-eng.htm


https://doi.org/10.1007/s00737-018-0866-6


https://doi.org/10.1177/107780040100700305

HealthyFamiliesBC. (n.d.). *Advice When Considering a Midwife or Doctor.* https://www.healthyfamiliesbc.ca/home/articles/advice-when-considering-midwife-or-doctor


mental health screening. *Journal of Affective Disorders, 186*, 90–94.

https://doi.org/10.1016/j.jad.2015.07.003


https://doi.org/10.1186/1471-2393-14-67


https://doi.org/10.1016/S0149-7634(02)00015-5


https://doi.org/10.1176/ps.2008.59.4.429


https://doi.org/10.1016/j.jad.2015.01.044


https://doi.org/10.1016/j.wombi.2016.04.004

Obstetrics & Gynecology, 110(5), 1102–1112.

https://doi.org/10.1097/01.AOG.0000287065.59491.70


Mental Health Commission of Canada. (2014b). Why investing in mental health will contribute to Canada’s economic prosperity and to the sustainability of our healthcare system (p.
https://www.mentalhealthcommission.ca/English/media/3104


https://doi.org/10.1097/NMC.0000000000000343


https://doi.org/10.1186/1471-2393-14-62


https://doi.org/10.1016/s0167-0115(02)00102-7


https://apps.who.int/iris/bitstream/handle/10665/152936/WHO_MSD_MER_15.1_eng.pdf?sequence=1


https://doi.org/10.1146/annurev-clinpsy-101414-020426
Appendices

Appendix A : Research Proposal Objectives

Page 1 of Proposal submitted to UBC BREB, certificate H17-01672. Note: since embarking on the project, I moved aware from the use of binary language such as “maternity care providers (MCPs)” in favour of Primary Antenatal Care Providers (PACPs), and “pregnant people” rather than “women”.

Introduction & Objectives

This project proposes a descriptive qualitative study to explore Maternal Care Provider (MCP) perspectives regarding the detection and support of women experiencing anxiety and/or depression during pregnancy. It aims to answer:

“What do MCPs consider barriers/facilitators to addressing anxiety and depression in pregnant women?”

Investigation of MCP perspectives and experiences in caring for pregnant women with anxiety and/or depression will elucidate how to be more responsive to the needs of Canadian women (Canadian Institute of Health Research, CIHR, 2014). MCPs are on the frontlines of care, the most frequent point of contact with the healthcare system for expectant mothers, and experts in their knowledge needs and implementation contexts. As such, they are in the unique position to leverage their expertise to raise awareness and generate change to better support Canadian maternal health outcomes, and the efficiency and comprehensiveness of maternal care/service provision.

Objectives: The goal of this project is to garner a deeper understanding of the challenges and complexities in addressing anxiety and depression during pregnancy from MCP perspectives. As
the main and most constant point of contact with the healthcare system, MCPs are instrumental in improving maternal health outcomes.

The study will be undertaken in overlapping phases according to the following objectives:

1. To investigate MCP attitudes and perspectives pertaining to: (a) anxiety and depression during pregnancy; (b) barriers and facilitators to identifying and supporting (i.e. screening, referral, management) women experiencing anxiety and/or depression during pregnancy from.

2. A. To hold a Community Meeting to engage stakeholders in discussion about this issue and build in a system of accountability to the patient population. This meeting will be held after MCP interviews have been transcribed, member-checked, and undergone preliminary, thematic analysis. The preliminary findings will be used to guide discussions

2. B. Develop and disseminate a MCP-targeted Knowledge Translation strategy to promote the identification and patient-centered support of women experiencing anxiety and/or depression during their pregnancies. Recommendations will be made based on objectives 1 and 2, above.

Objectives 1 and 2. A. culminate in 2. B. All are geared toward improving the provision of maternal mental health care and subsequent short and long-term health outcomes for pregnant women and their families living in British Columbia.
Appendix B: Informed Consent Form

Per UBC BREB certificate was H17-01672. Note: since embarking on the project, I moved aware from the use of binary language such as “maternity care providers (MCPs)” in favour of Primary Antenatal Care Providers (PACPs).

Study Title: Addressing anxiety and depression during pregnancy: maternity care provider perspectives

Study Team:
Principal Investigator: Dr. Hamideh Bayrampour
Midwifery, Department of Family Practice
University of British Columbia
Dr. Hamideh Bayrampour
Hamideh.bayrampour@ubc.ca

Student Investigator:
Ms. Julia Santana Parrilla
School of Population & Public Health
j.s.parrilla@alumni.ubc.ca

Co-Investigator:
Dr. Susan Cox
Center for Applied Ethics
Hamideh.bayrampour@ubc.ca
suecox@exchange.ubc.ca

Purpose of the study: this study aims to find out what is working and what requires improvements in current maternal health care so that women in British Columbia (BC) can receive better supports and access to maternal mental health. The purpose of this research is to investigate and describe the ways Maternity Care Providers (MCPs) address anxiety and depression during pregnancy.

Study Procedures: one-on-one interviews are expected to last 30-60 minutes, depending on the length of answers, recorded with your permission for later transcription. The interviewer may take notes during the conversation to remember to ask you specific points. These interviews will be conducted at a mutually convenient time and location. During the interview, you will be asked
about your experiences caring for women experiencing anxiety and/or depression during pregnancy.

In total, fifteen MCPs will be interviewed, including Family Practitioners, Obstetricians/Gynecologists, and Midwives who are providing antenatal care within the Vancouver Coastal Health Service Delivery Area.

Please feel free to ask questions at any time.

Study Results: the interviews will be used to inform Knowledge Translation and an inventory of resources to support a woman-centered approach to addressing anxiety and depression during pregnancy. The results will be published in JSParrilla’s Master’s Thesis, in a public report, and academic journal articles.

Knowledge Translation: to further inform the Knowledge Translation component of this study, a Community Meeting will be held with stakeholders (e.g. patients, informal care givers, decision-makers) to review the preliminary findings of this study. The meeting will provide the opportunity to discuss what was captured/missed in MCP interviews as well as build in a system of accountability to the patient population.

Should you like to be contacted to participate in the Community Meeting, please indicate:

Yes        No

Potential risks of study: there are no direct risks to you for participating in this study as we will be discussing experiences of your day-to-day practices as a MCP. You need only answer questions or express your views when you wish and can deny answering at any time.

Confidentiality: your name and the names of anyone else mentioned will be kept strictly confidential by the research team. You will receive a numbered pseudonym and only the coinvestigators (as listed above) will have access to your identifying information. Documentation
with your identifying information will be kept separate from documentation with your pseudonym for security. Signed consent forms will be kept in a locked filing cabinet in the Midwifery Program at the University of British Columbia and will be destroyed after 5 years. All digital files will be kept on a password-protected, encrypted disk computer in Midwifery. Only the research team listed on this consent form will have access to the files.

In any publications that result from this study, all personal details and identifying information will be changed so that testimonies cannot be traced to anybody.

**Withdrawal of consent:** you are not required to answer any particular question and are free to withdraw from the study at any time until one month after the interview has been completed. If you withdraw from the study before the one month cut-off, we will destroy your audio recordings and transcripts.

**Report of findings:** If you would like to receive a final summary of the of the findings, the resultant Knowledge Translation component, and/or would like to be invited to participate in the Community Meeting, please leave your email address below.

**Contact information in case of questions:** If you have any questions or would like further information about the study, you may contact Julia Santana Parrilla via email at j.s.parrilla@alumni.ubc.ca with them, or request a telephone call.

**Contact in case of complaint:** If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.
Consent: your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study without consequence to you. You have the right to ask questions and/or withdraw at any time.

Your signature confirms: (1) you understand the purpose and procedures of this study and consent to participate; (2) any questions have been answered to your satisfaction; (3) you have received a copy of this consent from for your records.

____________________________    _______________________
Participant signature                      Date

____________________________    _______________________
Participant name (print)                      Investigator signature
Appendix C: Case Study Vignette


“Jen is a 35-year-old primiparous woman. She and her partner, Pete, are expecting their first baby after 5 years trying to conceive. Jen plans to leave her work as a primary school teacher at 36 weeks and spend the next 5 years at home looking after the baby. Jen has been attending all antenatal care; her EPDS [Edinburgh Postnatal Depression Scale] scale during her first trimester scored at two, and her ANRQ [antenatal risk questionnaire] score was eleven (the highest scoring item indicated that she ‘‘likes to have a tidy house’’). Pete has contacted the [insert MCP sub-group, i.e. midwife; OB/GYN; GP] now that Jen is in her third trimester saying he is concerned about Jen, she seems to be crying all the time for no reason and the house is the most untidy he has ever seen it.”
Appendix D : Interview guide

Per UBC BREB certificate was H17-01672.

My name is Julia Santana Parrilla and I am a Master’s of Science student at the University of British Columbia’s School of Population & Public Health. I am part of a team of health researchers working to improve prenatal mental health care. This interview aims to engage you in discussion about your experiences in addressing anxiety and/or depression during pregnancy. The interview should last 30-60 minutes, depending on the length of answers. During this interview, please be sure not to refer to any particular patient by name. All identifying information will be anonymized during transcription.

Tell me a little bit about yourself, how long you’ve been a Maternity Care Provider (MCP), and what drew you to this line of work?

Could you set the scene for a typical “day on the job” for you?

I am wondering if you could walk me through how you would approach the following situation: “Jen is a 35-year-old primiparous woman. She and her partner, Pete, are expecting their first baby after 5 years trying to conceive. Jen plans to leave her work as a primary school teacher at 36 weeks and spend the next 5 years at home looking after the baby. Jen has been attending all antenatal care; her EPDS [Edinburgh Postnatal Depression Scale] scale during her first trimester scored at two, and her ANRQ [antenatal risk questionnaire] score was eleven (the highest scoring item indicated that she “likes to have a tidy house’’). Pete has contacted the [insert MCP sub-group, i.e. midwife; OB/GYN; GP] now that Jen is in her third trimester saying he is concerned about Jen, she seems to be crying all the time for no reason and the house is the most untidy he has ever seen it.”
Are you familiar with the EDPS? Do you use it? Are there other devices you might use? Why/why not?

How regularly do you encounter women experiencing anxiety and/or depression during their pregnancies?

In your opinion, what would be the best way to support women who are having these experiences?

What resources are you aware of to support women experiencing mental health challenges during pregnancy? Online? In the community? Internal/external referrals?

What barriers/ facilitators have you faced in supporting women experiencing anxiety and/or depression?

This next part of the interview is intended to inform the Knowledge Translation component of this study. I hope to garner an understanding of factors to be mindful of in the development and dissemination of the strategy.

In your opinion, what are some of the common reasons evidence-based knowledge doesn’t get implemented in care settings?

In your experience, what would be essential to ensure the uptake of a new care strategy/approach? What would be a motivating factor for you?

** include a probe about how important they think it is for patients to tell their stories**

We are close to the end of our time together, but before we draw to a close, do you have any questions regarding your involvement in this study or about any of the questions you have been asked today?
Thank you for your participation. I will follow up with you after you interview has been transcribed. I would like to also take this opportunity to extend an invitation to participate in a Community Meeting (DATE) with other stakeholders, including the patient population, to discuss the preliminary findings from the interviews and fill in any gaps. Does this interest you? If so, may I email you an invitation at a later date? Thank you again, I will be in touch soon.
Appendix E: Recruitment email

Per UBC BREB certificate was H17-01672 and as guided by UBC Clinical Research Ethics General Guidance Notes [https://ethics.research.ubc.ca/ore/ubc-clinical-research-ethics-general-guidance-notes]

Dear ____,

[Please disseminate the following research opportunity among your professional networks]

My name is Julia Santana Parrilla and I am a Master’s of Science student at the University of British Columbia’s School of Population & Public Health. I am part of a team of health researchers working to improve antenatal mental health care. The Primary Investigator of this project is Dr. H. Bayrampour (Hamideh.Bayrampour@ubc.ca).

We are conducting interviews with Maternity Care Providers about your experiences in addressing anxiety and/or depression during pregnancy. It is a priority for us to make sure that your voices contribute to efforts to improve existing strategies of care to be more responsive to antenatal needs in British Columbia.

Interviews will last 30-60 minutes at a mutually agreed upon location in your area and will cover a range of topics, including your experiences: identifying women with mental health challenges during pregnancy; supporting these cases; implementing knowledge/new care models you’re your care setting(s).

If you are interested in participating in the study and currently provide antenatal care within the Vancouver Coastal Health Service Delivery Area, please click here [embed j.s.parrilla@alumni.ubc.ca]. Please provide some available meeting times within the next month. In return, you will receive a confirmation email with your scheduled time slot.
If you have any questions, please do not hesitate to respond to this email with them.

Sincerely,

Julia Santana Parrilla

MSc Candidate, 2018

University of British Columbia
Appendix F: Recruitment presentation slideshow and presentation guide

Per UBC BREB certificate was H17-01672.

F.1 Guide

Hello,

Thank you [insert office; clinic; department name] for the opportunity to present. My name is Julia Santana Parrilla and I am a Master’s of Science student at the University of British Columbia’s School of Population & Public Health.

[Acknowledgement of ancestral lands]

I am part of a team of health researchers working to improve antenatal mental health care. The Primary Investigator of this project is Dr. H. Bayrampour (Hamideh.Bayrampour@ubc.ca).

We are currently recruiting Maternity Care Providers (MCPs) for interviewing about your experiences in addressing anxiety and/or depression during pregnancy. It is a priority for us to make sure that your voices contribute to efforts to improve existing strategies of care to be more responsive to antenatal needs in British Columbia.

Interviews will last 30-60 minutes at a mutually agreed upon location. I am able to meet you here or elsewhere, if necessary. We will cover a range of topics, including your experiences:

- identifying women with mental health challenges during pregnancy; supporting these cases;
- implementing knowledge/new care models into care setting(s).

If you are interested in participating, please take a card. It summarizes what I’ve said here today and has my contact information.

Any questions?

Thank you, again.
“Addressing anxiety & depression during pregnancy: Maternity Care Provider perspectives”

A study by:
Julia Santana Parrilla, MSc, candidate
Dr. Hamideh Bayrampour, PhD
Dr. Susan Cox, PhD

Anxiety &/or depression during pregnancy

- ~ 1/3 women may experience anxiety symptoms during pregnancy (Bayrampour, McDonald, & Tough, 2015)
- 10% of Canadian women experience depression during pregnancy (Public Health Agency of Canada, 2012)
- less than 15% of women experiencing anxiety or depression (WAD) receive needed mental healthcare [Kingston, D., et al]
- Women are reluctant to trust their MCPs to address concerns about antenatal depression, fetal medication exposure (medicating their symptoms), and held apprehensions about endangering their parental rights (being viewed as unfit to care for their child/children) (Kopelman et al., 2008)
Your role

The goal of this project is:

- to garner a deeper understanding of the challenges and complexities in addressing anxiety and depression during pregnancy from MCP perspectives.

MCPs are:

- on the frontlines of care;
- the most frequent point of contact with the healthcare system for expectant mothers;
- experts in their knowledge needs and implementation contexts;
- in the unique position to leverage their expertise to raise awareness and generate change to better support Canadian maternal health outcomes, and the efficiency and comprehensiveness of maternal care/service provision.

Interested?

Email Julia to set up an interview:

j.s.parrilla@alumni.ubc.ca

Or call:

604-440-9904

Thank you!
Appendix G : Recruitment cards

Per UBC BREB certificate was H17-01672 to accompany and supplement recruitment, the following cards were made available during and after the study presentations.
Appendix H: Interpretive Description Narrative Exercise (Sally Thorne, 2008).

Research Questions:
1. What are PACP’s attitudes and perspectives related to addressing anxiety & depression during pregnancy?
2. What are the barriers and facilitators PACPs can take into consideration to drive change?

Narrative Summary of Results

I set out to investigate what are PACP’s attitudes/perspectives regarding anxiety & depression during pregnancy? In doing so, PACPs revealed feeling unprepared and unsupported in addressing and managing their patients who experience anxiety & depression during pregnancy. This became apparent in how their current practice in identifying high-risk cases & anxiety & depression during pregnancy is often inadequate. Often, much of their care delivery depends on compensating for their perceived lack of training, resources, etc.

1. When it comes to identification, attitudes range from complacency to outright rejection of recommended tools.
2. When it comes to management, PACPs perceive their role to be supportive rather than diagnostic. As such, for them, as for their patients, their families, they result in PACPs over-scrutinizing themselves with the responsibility to compensate for this scarcity.

The limitations to their training and demands of their programs exacerbates PACP’s worries re: continuity of care & health outcomes for AP & their families.
### Appendix I: Comprehensive table of interview data

Per interview questions (Appendix C) and my Interpretive Description (Chapter 3: Results)

<table>
<thead>
<tr>
<th>Theme / sub-theme</th>
<th>Interview Question</th>
<th>Example Quote</th>
</tr>
</thead>
</table>
| **It’s a common experience among their patients** | **3.2.1.1** Sub-theme of: Attitudes and perspectives toward anxiety and depression within their practice | “How regularly do you encounter people experiencing anxiety and/or depression during their pregnancies?”  
“It’s a common experience among their patients”  
“3.2.1.1” Sub-theme of: Attitudes and perspectives toward anxiety and depression within their practice  
“… I would say a fair amount. Um… sometimes people come with pre-existing conditions that need to be monitored [but] often I would see it, um, like developing later on, or of course post-partum as well.”  
“I feel like I’m seeing a lot more people that are really stressed out. Whether you call it an anxiety disorder, or whether you actually give it a name like that, or whether they need medication or whether they’re depressed, but just like the overall vibe is more anxious.”  
“Out of all my pregnancies… I would say… the number is pretty high […] around like 60/70%, maybe more?”  
“If I see 25 women in a day, typically I would say at least… 3 or 4 of them have some sort of either past history, current anxiety or depression”  
“I tend to have a lot of those patients. I think we have um… Vancouver’s different […] it’s higher than I would expect.”  
“Probably 10% of my practice, I would say.”  
“[...] in my experience and I know there is like literature that women do have like first episodes of depression and anxiety in pregnancy and also postpartum […] think a lot of women do have,” |
| **Pregnancy is a vulnerable time**             | **3.2.1.2**                                                                         | “[...] in my experience and I know there is like literature that women do have like first episodes of depression and anxiety in pregnancy and also postpartum […] think a lot of women do have,” |
have had some experience of maybe mild depression or some concerns about their mental health prior and then you know, different things during pregnancy can worsen that.” [1, FP]

“I’ve had a couple women whose mental health ha – has very significantly deteriorated in pregnancy […] most women that I’ve seen have has some risk factors for that previously […] I’ve had a couple of women where there actually wasn’t any risk factors. Um, yeah, I, I mean, it’s common […] not having any risk factors doesn’t… like, exclude the possibility of you having like a serious mental health concern in your pregnancy. ” [1, FP]

“[…] many people are just anxious or stressed in general, so they don’t see it as, as an issue and they’ve been like that for most of their life […] I do think that pregnancy could be a really great opportunity to take a pause in some of those ways.” [4, FP]

“I think that a lot of us are more stressed out than we realise in our world, so then within pregnancy it just emphasises that even more. Um, especially when society and this culture is telling you so many things about how you have to be as a mom and there’s so many outside pressures […] I mean, what would be helpful? Like, changing that!” [4, FP]

“[…] sometimes people come with pre-existing conditions that need to be monitored […] but often I would see it, um, like developing later on, or of course postpartum as well.” [5, FP]

“[…] many people are, they don’t want it to be them, so they’re in denial for quite a long time. Until it’s undeniable […] it just don’t want it to be you!” [8, RM]

“[…] could be as high as 10% […] I think a lot of them have it predisposed.” [10, ObGyn]
<table>
<thead>
<tr>
<th>Through standardized screening 3.2.2.1</th>
<th>“I see it a lot more in my first time moms.” [10, ObGyn]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-theme of: Attitudes and perspectives towards identifying anxiety and depression during pregnancy</td>
<td>“[… ] I’m familiar with it, I have to say I do not do it on every single woman.” [1, FP]</td>
</tr>
<tr>
<td></td>
<td>“No. I mean, we give it… honestly, we often just give it as within the paperwork […] it’s in the folder. You know, we are, we can fill it out or not, and we can also hive it to the parents and fill it out or not […]” [6, RM]</td>
</tr>
<tr>
<td></td>
<td>“Yep. So, we use it routinely and, um, give it to everybody at usually 28 – around 28 weeks, so… 28 to 32 probably. […] some people we have them fill it in in the office if there’s time [but] I tend to get people to complete it with me there [and] then discuss it immediately after.” [7, RM]</td>
</tr>
<tr>
<td></td>
<td>“I give it to them. So, I give them a copy […] and when they bring it back, I triage the findings of the EPDS to determine how best to follow it up” [9, RM]</td>
</tr>
<tr>
<td></td>
<td>“I have to admit, I don’t use it that much […] all of our patients were supposed to be filling it out, but it didn’t seem to be identifying things particularly well.” [10, ObGyn]</td>
</tr>
<tr>
<td></td>
<td>“I don’t use it too often to be honest with you […] it’s kind of a cumbersome tool for us.” [11, ObGyn]</td>
</tr>
<tr>
<td>Perceived relevance and validity of screening tools 3.2.2.1.1</td>
<td>“in my case, I almost never use validated scales ‘cause none of them are validated for the people I work with. And it just kind of, it just never works. […] I have become much more adept at um... like asking all the normal questions I would to assess someone’s mental health, but I don’t use the questionnaires because they, they just never… it just doesn’t work.” [2, FP]</td>
</tr>
<tr>
<td>Perceived harms of screening using standardized tools</td>
<td>“Clinical assessments, but not tools. […] there’s a bit to talk about emotion for sure at every visit […] we do have those tools, um... personally, I, I very rarely use them […] I feel like it is quite isolating and I feel like it is quite stigmatizing.” [6, RM]</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Using screening tools selectively</td>
<td>“I think there is absolutely a role for questionnaires. I think you can get a lot more… history about what the woman’s going through and a lot more nuance by asking them to talk and like getting a sense also of what’s going on […] there’s like so many social and environmental triggers that I think that the questionnaire really misses.” [1, FP]</td>
</tr>
<tr>
<td>Through other means</td>
<td>“[…] if I’m ever assessing women for depression and anxiety I do tend to use a, a scoring questionnaire, not to much to make the diagnosis, but um.. more so as to like monitor and track it over time […] it’s like a very complicated issue and like having someone fill our a check list and then diagnosing them with like anxiety or depression is a bit crass [but] it normalizes it quick a bit as well.” [1, FP]</td>
</tr>
<tr>
<td>Sub-sub-theme of: Attitudes and perspectives towards identifying anxiety and depression during pregnancy</td>
<td>“I don’t have a screening […] I think that I’m really good at making people feel not judged by me.” [3, FP]</td>
</tr>
<tr>
<td>Sub-theme of: Attitudes and perspectives towards identifying anxiety and depression during pregnancy</td>
<td>“[…] if it changes and I, I try to actually repeat that multiple times if there’s any concerns.” [5, FP]</td>
</tr>
<tr>
<td>Sub-sub-theme of: Attitudes and perspectives towards identifying anxiety and depression during pregnancy</td>
<td>“Are there other devices you might use? Why/ why not?”</td>
</tr>
</tbody>
</table>
| Using clinical judgement and seeing the signs | \[7, RM\] “I guess, informal flags or warning signs for us [so] either administer the, this tool soon than later, um, or just have a conversation with them […]”  
\[7, RM\] “[…] when someone’s pattern of behaviour is not usual.”  
\[8, RM\] “[…] sometimes things develop in the pregnancy or there would be like some warning signs […] but I feel like a lot of the times we were sort of just like waiting and watching for something to happen […]”  
\[11, ObGyn\] “[…] I use sort of um, my own screening approach. Who knows if it works or not [but] people tend to tell me and we talk to talk about it.” |
| --- | --- |
| Relying on person-provider rapport for disclosure | \[1, FP\] “I will just ask like a, like a question [and] I usually like will normalize that saying ‘this is really common in pregnancy [and] sometimes we can have a hard time talking this like ‘is this something you’re experiencing?’”  
\[3, FP\] “I’m really open and I always encourage […] like: ‘is there anything else what you want to address?’”  
\[4, FP\] “[…] my usual approach to patients in general is trying to be quite open and receptive in the way that I always start with: ‘so, how are things going?’”  
\[4, FP\] “[…] people like to feel connected. Connection and trust, um, are like the utmost important.”  
\[7, RM\] “I try to start my visits with a “check-in” and “how are you doing” and sometimes for some people that’s a big list of physical…like, a laundry list of “oh, ok, these are – this is what’s happening: I feel this, I feel that” and I’m like: ok, so we’ll work through those. Some people understand it as a, um… like, like “how are you coping?”” |
“I frame it in that, you know, “perinatal mental health is very important, we know through, you know, more and more media accounts that this can affect anyone at any time, regardless of who you are, and…and your background, so we really like to, you know, just check in with you, because we want to see how you’re doing and if you have any concerns about your mental health; how’s your mood? Uh, how do you feel about the baby coming? Um, you know, maternity leave...” and just really open it up.” [9, RM]

“[…] talk to them about it. See what’s, what’s going on for them, what are they feeling […] how are they coping, what’s bothering the,, what’s… is there something in particular that’s giving them anxiety.” [12, ObGyn]

<table>
<thead>
<tr>
<th>The need to tailor for relevance</th>
<th>“In your opinion, what would be the best way to support pregnant people who are having these experiences?”</th>
</tr>
</thead>
</table>
| 3.2.3.1 Sub-theme of: Attitudes and perspectives towards anxiety and depression management during pregnancy | “[…] I think the ‘best case scenario’ is they sort of have sort of a team around them that communicates well. […] it’s just like – and trying to navigate and see which fit is best for the woman in front of you is challenging. Especially, you have so much time ] as a Family Doctor, you have pretty limited time, because your clinic is already pre-booked […] I think having like those people as part of a team and treating it as a team but like while maintaining the connection ‘cause I think it’s also really… damaging to the woman to say like ‘we’re going to deal with your pregnancy stuff here, but now that you’re having depression and anxiety, you have to go see the psychiatrist […] it’s like not very integrated.” [1, FP]

“Well, early identification and attachment to some kind of, um, either case management, a… a team […]” [2, FP]

“It would be really…great if there was an easier pathway to some kind of in-between step, like either a nurse that could assess them and maybe offer some social supports, offer some counselling… um, and then if they continue to,
um, either deteriorate or need more they could then see a psychiatrist.” [2, FP]

“it would be nice to have. Like they have mental health teams for all these different areas, but it would ne nice to have some kind of… integrated service that included counselling […] some sort of case coordination and, you know, social work who can address some of the social determinants of health.” [2, FP]

“[…] see what the difference that makes of having longitudinal care and people that you feel safe around and that you trust and what it really means to support moms and fetuses to be healthy children and families.” [4, FP]

“to, you know, to help mothers to keep their power or gain back their power.” [6, RM]

“[it] is a little bit tricky because, especially for people who don’t have a shitory of anxiety that, or depression, that, um, you can, you can sometimes offend people… or alienate them.” [7, RM]

“[…]sometimes you do have to ask it in different ways because a lot of people only expect…like: “how is the pregnancy going” as a, as a physical change. So, learning how to find other language, um… to, to try to get more information. Especially with someone who s – y’know, seems to be, to be struggling, but is telling you “everything’s great” um, and then, then that’s harder because you’re not getting that connection, you’re not feeling like you’re getting the story.” [7, RM]

“I wish there were more things that we’re like ‘you need to go see this doctor and pathologize this right away’ because a lot of the things I feel like maybe could be averted if people had good, like health – like strategies for coping with stress.” [8, RM]
"So, regular care by known care provider, access to information, referrals as appropriate, and baseline human needs taken care of. And medication! Like, if, if that’s what keeps her mood stable. Um, absolutely! Like, I’m very pro, pro-keeping people… stable and functional. Um, because the alternative is quite miserable." [9, RM]

"So, kind of customizing that person’s situation so that they have the best chance at …keeping that depression and anxiety kind of at the lowest level it can be. If it’s new on set. " [9, RM]

“[…] it’s very important [to] have teams that are cohesive and com, and communicate really well while we’re caring for these complicated patients […]” [10, ObGyn]

“I think it’s very… it’s somewhat patient-specific in how severe it is, right? Even what their situation is. […] for some it’s as simple as encouraging them to have family come over from wherever they are. Um, but it’s complicated […] I think the important thing is to assess it and then to figure out with each individual patient what’s going to work.[…] I think you have to tailor it to each patient.” [10, ObGyn]

“[…] different understanding of mental health, different, different ways of being in pregnancy. Um… just, you know, a huge range of cultural affect even. In pregnancy and through childbirth. Different dynamics with their partners. Often are, are, culturally relative for sure. So, it, it makes it more difficult.” [12, ObGyn]

| the need to manage expectations and normalize emotion | “[…] the best way would be to let them know that it’s common, and to offer support through regular visits, and to recommend that they do like maintenance things like exercise and eating well.” [3, FP] |
| Attitudes and perspectives towards anxiety and depression management during pregnancy | “[…] I always make quite a point to just normalize but also get any information that we can to sort of think about what may come up. […] to really listen to them and say: oh, is this something that’s like worried you before?” [4, FP] |
| — | “I always make quite a point to just normalize but also get any information that we can to sort of think about that may come up.” [4, FP] |
| — | “So, just kind of normalizing what’s going on and having them feel accepted and that this is not, um, abnormal or something that needs to be hushed or kept quiet […] making them feel accepted is probably key.” [5, FP] |
| — | “[…] it’s a full-on change and, you know, it’s quite demanding […] there’s a lot of reward in it, but there’s also a lot of emotions that rise. […] there’s also the normalisation of emotion and, and transition […] there’s so much tension, there’s so much pressure, there’s so much unknown […]” [6, RM] |
| — | “[…] just re-affirming with her that, um, what’s happening to her is, like, of course not her fault, that it does happen to people in pregnancy [and] we’ll figure it out together.” [8, RM] |
| — | “[…] see them on a regular basis, talk to them on a regular basis, try to reassure them […] try to educate them, try to bring the fear down […]” [10, ObGyn] |
| — | “[…] I tell them it’s exceedingly common. Um, and if there’s any changes in their mood it can be related to the pregnancy and I would just like them to talk to me about it.” [11, ObGyn] |
| What supports and resources exist to support mental health during pregnancy | “What resources are you aware of to support people experiencing mental health issues?” [1, FP] |
| — | “[…] I mean, there’s a lot out there, it’s, I think… just finding what fits the patient in front of you […]” [1, FP] |
### 3.2.3.3

Sub-theme of: Attitudes and perspectives towards anxiety and depression management during pregnancy

<table>
<thead>
<tr>
<th>“if there is either like a relapse of their mental health issue or something occurs, like I actually refer pretty much all my patients to Seamless because they all qualify whether or not they have mental health issues. Um, then at least they have a few wrap-around services.”</th>
<th>[2, FP]</th>
</tr>
</thead>
<tbody>
<tr>
<td>“[…] I just, I do feel like there’s not many options. Um, so that also frustrates me […]”</td>
<td>[4, FP]</td>
</tr>
<tr>
<td>“I find that there’s good supports with the community health… um, like nursing team that comes to the home.”</td>
<td>[5, FP]</td>
</tr>
<tr>
<td>“That’s the thing, uh, because it’s a little bit dismantled […]”</td>
<td>[6, RM]</td>
</tr>
<tr>
<td>“I feel as though there is a, like a shortage or resources right now. So, I know that getting into Reproductive Mental Health has a very long waitlist […] and some people who do or would consider counselling can’t afford it.”</td>
<td>[7, RM]</td>
</tr>
<tr>
<td>“there’s limited stuff for us in – well, everywhere. Um, we have Reproductive Mental Health through the hospital […] and then I have a list of a couple of counsellors that are, are, that I’ve just collected […]”</td>
<td>[8, RM]</td>
</tr>
<tr>
<td>&quot;I certainly refer to community-based counsellors as well if they have benefits. I would say - everyone could use a counsellor! It’s not just you!”</td>
<td>[9, RM]</td>
</tr>
<tr>
<td>“[…] midwives and they provide this postpartum care that’s really much more comprehensive and much better [and] that actually can often make a big difference […]”</td>
<td>[10, ObGyn]</td>
</tr>
</tbody>
</table>

So, most of our resources are pregnancy-specific. Repro’ Mental Health is who we connect them with […] ‘cause nobody really seems to see pregnant women […] most of the resources are
not really suitable for pregnant women.” [11, ObGyn]

“We do have a fairly good and responsive uh, reproductive mental health team that we can access. So, we get them referred to there.” [12, ObGyn]

“[…] just the wait time at Reproductive Mental Health and maybe also I know that the files are closed when they’re one year postpartum. Which makes sense from like a pregnancy related resources, but it.. that’s the usually, or sometimes they don’t resolve their issues by one year, so they’re left high and dry.” [3, FP]

“[…] cost is a barrier for the patient. And also a barrier is I have no idea who’s a good counsellor […]” [3, FP]

“[…] depending on income like what their options are and what – you know what resources they have to put into their own mental health. Um, that I find a big barrier in terms of therapy. […] it’s not covered so a lot of people ha – have a lot of issues with going […]” [5, FP]

“So, to do a scale and it’s actually accurate, but you don’t give me any tools to respond to that, then I actually think it’s more damaging […] I can actually trigger a patient and if I don’t have the skill to respond to the trigger I just did then I think it’s actually – I think it’s not safe to do.” [6, RM]

“It’s weird that counselling isn’t… covered. Like, that mental health support that isn’t pharmacological isn’t covered […] I’m sure, if funding, if counselling was covered I’m pretty sure every Family Doctor would try referring to counselling […]” [8, RM]

“It can be kind of a long wait to get them in to see Reproductive Mental Health. […] often there’ll be a 3-6 month wait […]” [12, ObGyn]
### Gaps in Training

#### 3.2.4.1

| Sub-theme of: Attitudes and perspectives towards the gaps in what is available and primary antenatal care provider capacity to address anxiety and depression during pregnancy |
|---|---|

“What barriers have you faced in supporting pregnant people experiencing anxiety and/or depression?”

“[…] it’s really time consuming to be able to provide the quality of care and counselling that I want to provide […] and it’s also then on you to connect them to sort of […] siloed resources in the community and once you make the referral it’s kind of a ‘black box’ in a sense.” [1, FP]

“So, time is a really big barrier in a primary care clinic. You have a lot of patient to see, you’re not… compensated for longer appointments and often times it sort of comes up in a regularly scheduled appointment and then you have a limited amount of time just because you have multiple other patients waiting. […] having the siloed nature is like a little bit of a barrier. Um, both in just like knowing how to make the referral takes time to look up like: ‘oh, who do I fax this to?’ […] it’s a barrier for the woman too, if she has to go to multiple different locations […] definitely like the siloed nature, and then I think a big problem is, depending on whether they end up seeing like another physician or not, you may not actually get anything back from the referral.” [1, FP]

“So, barriers… Um, I think are the um, fragmented services. So, they exist, but I’m relatively new to Vancouver, so I certainly don’t know all of them. […] not everybody is familiar with like if people don’t yet have MSP […] language barrier is a big one. Um, and sort of like cultural barriers.” [2, FP]

“[…] if they are part of a minority group, I have no idea what cultural or community resources exist, so that’s a barrier.” [3, FP]

“[…] the provider can certainly, uh, be a barrier […] it’s a very very demanding profession […] perinatal depression is the number one issue in pregnancy, not, you know, preeclampsia, and not, you know, whatever, it’s perinatal depression [and] we’re so not educated in it […] Not a really good understanding of what it is […] the provider also needs more support and
education, but also um, in their own mental health and exhaustion.” [6, RM]

“Well, barriers would be, probably our, our training isn’t fantastic. We take, at least through the [university] program, there’s one counselling course that’s required. Um… as, as part of our training.” [7, RM]

“[…] I felt like just like not able to provide the care that she needed. [...] we all wish that there was like even just a better guide for us.” [8, RM]

“[…] like, I’m not a counsellor […] so when I do into a situation where I’m trying to support something through something I do kind of feel like ‘this person needs more support than I am able to offer.’ So, like, I try to do my best.” [8, RM]

“I provide general ObGyn services so I’m certainly not a sub-specialist in mental health […]” [11, ObGyn]

<table>
<thead>
<tr>
<th>Time and its role in gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.4.2</td>
</tr>
<tr>
<td>Sub-theme of:</td>
</tr>
<tr>
<td>Attitudes and perspectives towards the gaps in what is available and primary antenatal care provider capacity to address anxiety and depression during pregnancy</td>
</tr>
</tbody>
</table>

“[…] a barrier is the time […] time not compensated for, unless there is a problem and then I would be able to bill it out accordingly kind of thing.” [3, FP]

“[…] the other issue is, is really just time. […] but it’s really like the time and just to access… to, to the resources that’s a barrier [and] the access to the – uh, to the reproductive psychiatry program is, um, long waitlist. […] I think probably the biggest thing is time.” [5, FP]

“[…] the biggest thing is time. […] we have so many patients in a day, we have our 10-minute appointments locked. […] adding in more just take up more time and that’ probably the biggest resour – uh, barrier to adding more resources […] it’s hard.” [5, FP]

“the provider can certainly be, uh, be a barrier. So, particularly in Midwifery, unfortunately, it is
a very, very demanding profession [and] you already have a lot of people wanting to reach you and very little support then it’s difficult to be fully present […] there’s a lot of demand on us.” [6, RM]

"It’s a little hard sometimes, too, because we come to every meeting with our own goals of, of what we need to get through clinically and, um, there’s…we have a student working with us right now, so there’s that added pressure of having your clinic run on time, so you… you feel that sometimes.” [7, RM]

“[it’s] a system problem obviously. If we are getting paid for our time, then we can use our time more wisely rather than trying to fit in more patients. […] if there were things like online handouts or like things that we could do [that] might shorten our own personal time.” [5, FP]

“[…] I think most people do spend more time with people, have more appointments, go do extra home visits. […] some don’t see it as their… their role […] I think it’s very mixed.” [8, RM]

“If there was a good resources that existed that was… affordable or free for people, I would use it right away […] as long as I knew it existed. Like everybody refer to Reproductive Mental Health because it’s the one thing we can do that doesn’t cost people money.” [8, RM]

"[…] working with a group of other providers who have a varied level of experience, being able to kind of… do some care planning and talk things through behind the, you know, before the visit, after the visit, make sure… – so, peer support for myself is helpful.” [9, RM]

### Gaps and the responsibility to fill them

#### 3.2.4.3

Sub-theme of: Attitudes and perspectives towards the gaps in what is available and primary antenatal care provider capacity to address anxiety and depression during pregnancy

<p>| Attitudes and perspectives toward what could help | “What facilitators have you faced in supporting pregnant | “I’m really biased toward liking to work in an interdisciplinary team because there’s a lot of… there’s I mean, first of all, you have a lot more |</p>
<table>
<thead>
<tr>
<th>Address anxiety and depression during pregnancy</th>
<th>people experiencing anxiety and/or depression?</th>
<th>time with the clients between all the different healthcare providers, um…. And it feels really nice to be able to share the burden of more complex patients” [1, FP]</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.5</td>
<td>“I think some of the facilitators, I mean, we are, as someone who’s worked rurally and here, like we are very lucky in the Lower Mainland because there is actually stuff that you can access […] I think like obviously just like awareness of resources […] what is available is a huge facilitator.” [1, FP]</td>
<td>“the way that we do, uh, that we provide care, I think that’s a facilitator. So, long period of time, try to break down the hierarchy, relationship between patient and provider, continuity of care… so we really know the patient and so we really know when something is kind of “up” [and] the frequency of seeing the patient, I think those are good, good, uh, good facilitators.” [6, RM]</td>
</tr>
<tr>
<td></td>
<td>“[…] as a midwife, we’re, we’re even more fortunate because we spend more time with people. So we have… the luxury actually compared to other care providers of time to address things and to provide, you know, preventative kind of support.” [8, RM]</td>
<td>“I don’t think we prevent it, but I think that, that they have lots of opportunities for check-in and for, to kind of manage their anxiety too – to ask questions, to get the answers, ask them again, and get the same answers” [9, RM]</td>
</tr>
<tr>
<td></td>
<td>“I think Repro’ Mental Health is it.” [11, ObGyn]</td>
<td>“I think healthcare providers take on a lot of responsibility, um, and a lot of worry and they – it’s very nice to be able to talk about that as a team and work together on that as a team and not feel that you are solely responsible for</td>
</tr>
</tbody>
</table>

**Attitudes and perspectives towards knowledge implementation in primary antenatal care settings**

“In your opinion, what are some of the common reasons evidence-based knowledge doesn’t...
| 3.2.6 | get implemented in care settings? | connecting this person to all the sorts of supports and resources that they *might* need.” [1, FP]

“[…] there’s just a lot of practical things that can be done in my like work context.” [1, FP]

“I think it’s like a 10 to 15 years average before like something gets like… adopted as like a common worldwide practice.” [1, FP]

“As you know, the time from like research to *actual* uptake is just really long for a million different reasons, but it can really take a long time for people to change a practice. […] reaching people on the frontlines is always a challenge […] it just gets added *on* to the things you’re already doing and then it just ends up taking a really long time and that can be, um, a major barrier for people, I think.” [2, FP]

“[…] time constraints [and] it’s hard to teach an old dog new tricks, so maybe there’s actually like physician resistance of changing their habits […] even though I knew that that’s the right way, it’s hard […] patient attitudes. It’s another barrier.” [3, FP]

“I find a huge barrier in, in implementing new things is I feel I don’t have the skills, or I don’t have the knowledge. So, I need to learn how.” [3, FP]

“it’s like, it’s not easy to implement if like you don’t have 40 minutes or it’s not online so someone can do it easily, or they don’t understand how to navigate […] how to practice it […] how easy it is to transition from the way that we’re currently providing to something new and how willing people are to change.” [4, FP]

“Doctors are, in general, Doctors and Midwives, it’s like you’re busy and you’re always… you’re always busy and you’re always pressed for time […]” [4, FP]
"As a practitioner you are already into your habits and it’s so demanding that, you know, a lot of us do not necessarily try to go out of the boundaries to try to implement something else."
[6, RM]

"things take a long time to change in healthcare."
[7, RM]

"Um, not enough time. So, full clinics. Um, just those… time, time pressures. Um, maybe just not being up-to-date." [7, RM]

“[…] it just feel like that’s another task on top of things […]” [8, RM]

“[…] one of them is timing. […] it could take years and years and years. It’s outrageous!” [8, RM]

“[…] part of it is that there is a huge amount of new information and as a clinician you just can’t read everything. […] and then you have to also appraise it and say: ‘is this, like… good enough to make a change?’ […] I think the biggest thing is a whole bunch of information and trying to suss out what is relevant and not.” [8, RM]

“I think maybe because there’s so much in obstetrics and perinatal care that it’s randomised control trialable. So, the like the gold, gold standard approach that may work in other fields doesn’t necessarily translate so well […] so there’s kind of this like: ‘we want to practice evidence-based medicine, but really is the evidence good enough?’” [9, RM]

“Um, people get stuck in their ways and as a clinician, you can have sentinel experiences that will shape their practice regardless of the evidence.” [9, RM]

“I mean, I read ten million things a day and I’m sure you don’t read enough things to be up to date on everything” [11, ObGyn]
<table>
<thead>
<tr>
<th>“Make it easier” to implement new knowledge, care recommendations and strategies</th>
<th>“[...] not being aware of the evidence-based medicine [...] there’s so many things in, uh, in obstetrics that’s just not evidence-based. So, some things don’t have good evidence yet for them. Um… personal bias, professional bias.” [12, ObGyn]</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.2.6.1 Sub-theme of: Attitudes and perspectives towards knowledge implementation in primary antenatal care settings</td>
<td>“A major issue it time. Like, finding the time to do that [...] there’s also no financial model for most physicians in the community to be doing um, the extra work like that.” [12, ObGyn]</td>
</tr>
<tr>
<td></td>
<td>“[...] good research on this like people who have their mental health and it was addressed.” [1, FP]</td>
</tr>
<tr>
<td></td>
<td>“[...] even just having a centralised website where there was like all the different resources because it’s like when you’re – when the patient is in front of you in that moment and you’re like trying to make a decision of what to do [...]” [1, FP]</td>
</tr>
<tr>
<td></td>
<td>“[...] I think like awareness is probably one of the biggest things. Once you’ve stopped learning or like stopping being in a formal learning process that’s really on you as a healthcare provider and of course people have different interests and different passions [...] the continuing medical education piece is a big one.” [1, FP]</td>
</tr>
<tr>
<td></td>
<td>“it would be nice if.. if you were to do something like that, like if there was a mandate either by a health authority or a hospital or it was on the antenatal – or Perinatal Services BC or whoever, then if those kinds of recommendations came with like research, right? Because that’s the other thing, people are like ‘screen for this’ and then, you know, what do you do?” [2, FP]</td>
</tr>
<tr>
<td></td>
<td>“[...] it should be integrated into the other kinds of programs that people do.” [2, FP]</td>
</tr>
<tr>
<td></td>
<td>“[...] if there is like a go-to page. Like, if you would write, you know ‘prenatal depression’ or</td>
</tr>
</tbody>
</table>
something like that and if it would be like ‘here are all the lists of the resources for the patient’ […]” [3, FP]

“[…] educate us on what are the new resources available, what’s the new evidence and how do we implement it […]” [3, FP]

“We have to try it, we have to try it on, we have to see how it works – like there’s a lot of, there’s a pretty similar way that that prenatal care is delivered compared to other types of care.” [4, FP]

“It has to be easy to implement. […] so it doesn’t really take up a lot of time. It’s something that’s easy for the patients and me to understand. So, it needs to be something that doesn’t take a lot of my time, the patients’ time and it’s easy to interpret and understand.” [5, FP]

“I think the easiest way to implement is to go through the students because they are the – they have the most elastic minds.” [6, RM]

”[…] I, I’m a fan of something that is easily just like implemented in the moment and um, can at least start the conversation if it, if it hasn’t already been started.” [7, RM]

“[…] if there was a tool basket, I feel like, like if there was a easy-to-use resources […] practitioners would be really glad to have it [like] ‘here’s this toolbox that we have of resources in the community.’ Like, make it easier!” [8, RM]

“Money! And the government! So the government decides how they’re going to fund us and what they’re going to pay for […] if they don’t put funding into programs to support mental health and wellness, then… then the programs don’t exist for us to refer people to.” [8, RM]
“[…] I would prefer to see something that’s like like: ‘here are some tools you can use’ rather than: ‘this is the one thing you should do with eveyrbody’ ‘cause that won’t work.” [8, RM]

“[…] there needs to be effective means of disseminating information from researchers to the providers. This is most often done through guidelines, at meetings, and in rounds.” [10, ObGyn]

“I mean it does come down to money at the end of the day. Right? […] no one’s going to do it for free!” [10, ObGyn]

“[…] things that are quick and easy and straightforward the best way to provide information […] factual information and not extensive that I can read quickly are helpful […] it needs to be something reasonably easy to do and needs to have good evidence behind it it’s I’m going to change my practice. Solid evidence behind it.” [11, ObGyn]

“I think there should be some means of um, disseminating information from tertiary care centers where they, they’re you know, more involved in research [and] says: ‘by the way, look at this that’s come out’ […]” [12, ObGyn]

Motivations to change

3.2.6.2

Sub-theme of: Attitudes and perspectives towards knowledge implementation in primary antenatal care settings

“What would be a motivating factor for you?”

“[…] in terms of nudging people to do like the right think like having it just like be these like easy, quick things where it’s already part of your EMR or it’s like on a centralised website that people already use and are accessing, that makes it easier.” [1, FP]

“I’m like more motivated if it’s like not a dramatic change, if it’s like something that I can already incorporate into the care that I’m like currently providing, like in the sense that it doesn’t take tones more time or like it’s um… like certainly like in terms of like making people aware of it, like providing like free continuing medical education that like certified and like so that people like van go to a talk or something
where they like can log it for like as part of the hours that we have to do […]” [1, FP]

“[…] the way doctors are paid really directs how care is provided, really at the end of the day […]” [1, FP]

“I think it’s a combination like you need to have the evidence [and] then making it really like personalised so that people can connect with it.” [1, FP]

“Part of it is just making it as low-barrier as possible. So like having it be as easy as possible to access is definitely going to be… make it more, people more motivated to use it […] I think everybody will want to help people with mental health concerns but like pragmatic pieces of it can be difficult.” [2, FP]

“I think incentivizing extra time being spent to counsel patients. Like, we already have that, we have incentives that if we spend 20 or more minutes counselling a patient who is stressed our, we can bill for that. So, that’s in there.” [3, FP]

“[…] if it is something that takes a bit more time in practice, incentivizing the time with patients. That would motivate me.” [3, FP]

“[…] they need to get excited about it, and be really excited about implementing something new, and so, they need to… know about the option, understand why it’s important, really believe in it, and then be able to take it forward together in a group, I think, and feel really supported and excited about it.” [4, FP]

“Honestly, if you gave me a scale, I would probably not use it [chuckles. Unless you then provide me with a clear response to this scale [because] I feel like it’s often that, like, questionnaires are systems of triggers [if] you don’t give me any tools to response to that, then
I actually think it’s more damaging. […] when a patient is triggered it’s when they are more at risk of… committing suicide, or doing substance abuse, of you know, getting into serious damaging behaviour […] assure that I can do something as a follow-up with it.” [6, RM]

“Give them a credit. Give them a continuing education point […] you do have to give some incentive.” [7, RM]

“I think if it was you know, thoroughly researched, well-presented, accessible, meaningful, um, and had demonstrated change and improved outcomes, I, I would not get in the way of… you know, spreading the word.” [9, RM]

“[…] there needs to be convincing evidence that the interventions will work that needs to also apply to the population that we work with.” [10, ObGyn]

“I think that you have to show that it helps patient outcomes [and] it has to be 100 […]” [10, ObGyn]

“A motivating factor would probably be professional satisfaction… for it. Knowing that, that what you do is going to, uh… better the outcomes for your patients and your patient care.” [12, ObGyn]

“What do you think the role of the patient voice is?”

“it’s hugely important. […] I think so much of healthcare has been done without the patient’s actual voice, it’s like ‘we’re being patient centered’ but it’s like no patient actually sits at the table when the decisions are being made” [1, FP]”

“Super important. […] one of the things I think would be really important to know from the patient perspective is like ‘where do you get health information?’ […] I just always think it’s really important for them to have, um, a voice in the development of all the materials just because
they are the… sort of like the end-users […] I think it’s their experience that we’re trying to change to some degree” [2, FP]

“I would be curious to hear what patient’s perspective is on like how anxiety-provoking is pregnancy and what does that feel can sometimes see things in different ways than patients can […]” [4, FP]

“[…] their voice is probably the most important because they are the ones that are kind of going through the issues and I think for a lot of people, especially in the antenatal period is very hard to come to terms with.” [5, FP]

“[…] the people themselves are the most important […] sometimes we’re just not aware […] sometimes we are the perpetrators that make them feel isolated and disempowered and silenced […] there’s a lot of psychological violence and you know that that’s need talk about in… in our research.” [6, RM]

“I think that’s very important [they’re] the people who could, who could, um, give some insight into what could have been better or what… what was done well or what was horrible. Um, yeah, I think it’s important.” [7, RM]

“[…] they are the ones that are more affected by it, they have the wisdom, they have the knowledge, they have the experiences, we’re just bystanders and facilitators. So… absolutely critical. You couldn’t develop something without them because it really wouldn’t have any meaning at all.” [9, RM]

“I think it would be very useful… to know what the patients find useful, of course. […] actually finding out what they feel would be useful resources for them. Um, how they would like to access the resources.” [12, ObGyn]
Appendix J: Inventory of mental health service and resources

J.1 For dissemination

<table>
<thead>
<tr>
<th>SERVICES AND RESOURCES</th>
<th>PERINATAL MENTAL HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For the purpose of this guide:</strong> Services refer to care options gauged by professionals. Resources refer to care options gauged by people, providers, and families for support.</td>
<td></td>
</tr>
</tbody>
</table>

**IN CASE OF CRISIS:**
Call: 310-6389
Visit: [https://www.cmsh.ca/](https://www.cmsh.ca/)

<table>
<thead>
<tr>
<th>SERVICES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists BC</td>
</tr>
<tr>
<td>Counselling BC</td>
</tr>
<tr>
<td>Reproductive Mental Health BC Women’s Hospital</td>
</tr>
<tr>
<td>Reproductive Psychiatry</td>
</tr>
<tr>
<td>Pacific Postpartum Society</td>
</tr>
<tr>
<td>Coast Pregnancy &amp; Postpartum Counselling</td>
</tr>
<tr>
<td>Fr Square</td>
</tr>
<tr>
<td>Shé-Wáy</td>
</tr>
<tr>
<td>BC Association of Perinatal Outreach Programs</td>
</tr>
<tr>
<td>Youth Pregnancy and Parenting Program</td>
</tr>
<tr>
<td>The Strathcona Midwives Collective</td>
</tr>
</tbody>
</table>
| **CULTURALLY SAFE SERVICES:** Umbrella Multicultural Health Co-op, N.U.V.C.E.E.S.
First Nations Doula Program |
| [http://www.cmsh.ca/](http://www.cmsh.ca/) |

**GENERAL SEARCH:**

<table>
<thead>
<tr>
<th>RESEARCH/ GUIDES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Mental Health Research Collaborative</td>
</tr>
<tr>
<td>Reproductive Mental Health Cogntive Behaviour Based Resource and Self Management Guides for Women and Their Partners</td>
</tr>
<tr>
<td>Reproductive Mood Disorders Awareness Project Ltd.</td>
</tr>
<tr>
<td>Perinatal Mood Disorder Awareness Project Ltd</td>
</tr>
<tr>
<td>Best Practice Guidelines for Mental Health Disorders in the Perinatal Period</td>
</tr>
<tr>
<td>Maternal Mental Health NOW</td>
</tr>
<tr>
<td>Perinatal Services BC</td>
</tr>
</tbody>
</table>

**MENTAL HEALTH THROUGHOUT LIFESPAN:**

<table>
<thead>
<tr>
<th>RESOURCES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Health Education Line</td>
</tr>
<tr>
<td>Healthiest Babies Possible</td>
</tr>
<tr>
<td>Best Beginnings</td>
</tr>
<tr>
<td>All-Options Prophylaxis Resource Centre</td>
</tr>
<tr>
<td>Perinatal Mood Disorder Awareness Project Ltd.</td>
</tr>
<tr>
<td>Postpartum Support International</td>
</tr>
<tr>
<td>Healthy Families BC</td>
</tr>
<tr>
<td>Pregnancy to Parenting</td>
</tr>
<tr>
<td>Power to Push</td>
</tr>
<tr>
<td>The Blue Dot</td>
</tr>
<tr>
<td>SmartMom Canada</td>
</tr>
<tr>
<td>OMama</td>
</tr>
<tr>
<td>PPO ACT</td>
</tr>
<tr>
<td><a href="http://www.cmsh.ca/">http://www.cmsh.ca/</a></td>
</tr>
</tbody>
</table>

**MENTAL HEALTH FOLLOW-UP:**

<table>
<thead>
<tr>
<th>BC Mental Health &amp; Substance Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Here to Help</td>
</tr>
<tr>
<td>Anxiety Canada</td>
</tr>
<tr>
<td>MindHealthBC</td>
</tr>
<tr>
<td>Canadian Mental Health Association</td>
</tr>
<tr>
<td>Kelly Mental Health Resource Centre</td>
</tr>
</tbody>
</table>

**MENTALLY HEALTHY BIRTH REPORT:**

<table>
<thead>
<tr>
<th>CULTURALLY SAFE MENTAL HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multicultural Mental Health Resource Centre</td>
</tr>
<tr>
<td><a href="http://www.cmsh.ca/">http://www.cmsh.ca/</a></td>
</tr>
<tr>
<td>First Nations Doula Program</td>
</tr>
<tr>
<td><a href="http://www.cmsh.ca/">http://www.cmsh.ca/</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INFO+ HUBS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Health Education Line</td>
</tr>
<tr>
<td><a href="http://www.cmsh.ca/">http://www.cmsh.ca/</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SELF-CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.cmsh.ca/">http://www.cmsh.ca/</a></td>
</tr>
</tbody>
</table>

---

**CULTURALLY SAFE MENTAL HEALTH:**

<table>
<thead>
<tr>
<th>CULTURALLY SAFE MENTAL HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multicultural Mental Health Resource Centre</td>
</tr>
<tr>
<td><a href="http://www.cmsh.ca/">http://www.cmsh.ca/</a></td>
</tr>
<tr>
<td>First Nations Doula Program</td>
</tr>
<tr>
<td><a href="http://www.cmsh.ca/">http://www.cmsh.ca/</a></td>
</tr>
<tr>
<td>Raven Song Community Health Centre</td>
</tr>
</tbody>
</table>

180
<table>
<thead>
<tr>
<th>Services and Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Perinatal Mental Health</strong></td>
</tr>
<tr>
<td>1. Psychotherapy/RC</td>
</tr>
<tr>
<td>2. Counselling/RP</td>
</tr>
<tr>
<td>5. Pacific Postpartum Program</td>
</tr>
<tr>
<td>8. BC Association of Pregnancy Outreach Programs</td>
</tr>
<tr>
<td>9. The B.C. Pregnancy &amp; Postpartum Program</td>
</tr>
<tr>
<td>13. Mental Health Services</td>
</tr>
<tr>
<td>14. Infant Mental Health Services</td>
</tr>
<tr>
<td>15. Child &amp; Family Services</td>
</tr>
<tr>
<td>16. Mental Health Services</td>
</tr>
<tr>
<td>17. Best Practice Guidelines</td>
</tr>
</tbody>
</table>

**Perinatal Services & Resources**

19. Maternal Child Health Services
20. Perinatal Services & Resources
21. Maternal Health Services
22. Perinatal Services & Resources
23. Maternal Child Health Services
24. Perinatal Services & Resources
25. Maternal Health Services
26. Perinatal Services & Resources
27. Maternal Health Services
28. Perinatal Services & Resources
29. Maternal Health Services
30. Perinatal Services & Resources
31. Maternal Health Services
32. Perinatal Services & Resources
33. Maternal Health Services
34. Perinatal Services & Resources
35. Maternal Health Services
36. Perinatal Services & Resources
37. Maternal Health Services
38. Perinatal Services & Resources
39. Maternal Health Services
40. Perinatal Services & Resources
41. Maternal Health Services
42. Perinatal Services & Resources
43. Maternal Health Services
44. Perinatal Services & Resources
45. Maternal Health Services
46. Perinatal Services & Resources
47. Maternal Health Services
48. Perinatal Services & Resources
49. Maternal Health Services
50. Perinatal Services & Resources
51. Maternal Health Services
52. Perinatal Services & Resources
53. Maternal Health Services
54. Perinatal Services & Resources
55. Maternal Health Services
56. Perinatal Services & Resources
57. Maternal Health Services
58. Perinatal Services & Resources
59. Maternal Health Services
60. Perinatal Services & Resources
61. Maternal Health Services
62. Perinatal Services & Resources
63. Maternal Health Services
64. Perinatal Services & Resources
65. Maternal Health Services
66. Perinatal Services & Resources
67. Maternal Health Services
68. Perinatal Services & Resources
69. Maternal Health Services
70. Perinatal Services & Resources
71. Maternal Health Services
72. Perinatal Services & Resources
73. Maternal Health Services
74. Perinatal Services & Resources
75. Maternal Health Services
76. Perinatal Services & Resources
77. Maternal Health Services
78. Perinatal Services & Resources
79. Maternal Health Services
80. Perinatal Services & Resources
81. Maternal Health Services
82. Perinatal Services & Resources
83. Maternal Health Services
84. Perinatal Services & Resources
85. Maternal Health Services
86. Perinatal Services & Resources
87. Maternal Health Services
88. Perinatal Services & Resources
89. Maternal Health Services
90. Perinatal Services & Resources
91. Maternal Health Services
92. Perinatal Services & Resources
93. Maternal Health Services
94. Perinatal Services & Resources
95. Maternal Health Services
96. Perinatal Services & Resources
97. Maternal Health Services
98. Perinatal Services & Resources
99. Maternal Health Services
100. Perinatal Services & Resources
101. Maternal Health Services
102. Perinatal Services & Resources
103. Maternal Health Services
104. Perinatal Services & Resources
105. Maternal Health Services
106. Perinatal Services & Resources
107. Maternal Health Services
108. Perinatal Services & Resources
109. Maternal Health Services
110. Perinatal Services & Resources
111. Maternal Health Services
112. Perinatal Services & Resources
113. Maternal Health Services
114. Perinatal Services & Resources
115. Maternal Health Services
116. Perinatal Services & Resources
117. Maternal Health Services
118. Perinatal Services & Resources
119. Maternal Health Services
120. Perinatal Services & Resources
121. Maternal Health Services
122. Perinatal Services & Resources
123. Maternal Health Services
124. Perinatal Services & Resources
125. Maternal Health Services
126. Perinatal Services & Resources
127. Maternal Health Services
128. Perinatal Services & Resources
129. Maternal Health Services
130. Perinatal Services & Resources
131. Maternal Health Services
132. Perinatal Services & Resources
133. Maternal Health Services
134. Perinatal Services & Resources
135. Maternal Health Services
136. Perinatal Services & Resources
137. Maternal Health Services
138. Perinatal Services & Resources
139. Maternal Health Services
140. Perinatal Services & Resources
141. Maternal Health Services
142. Perinatal Services & Resources
143. Maternal Health Services
144. Perinatal Services & Resources
145. Maternal Health Services
146. Perinatal Services & Resources
147. Maternal Health Services
148. Perinatal Services & Resources
149. Maternal Health Services
150. Perinatal Services & Resources
151. Maternal Health Services
152. Perinatal Services & Resources
153. Maternal Health Services
154. Perinatal Services & Resources
155. Maternal Health Services
156. Perinatal Services & Resources
157. Maternal Health Services
158. Perinatal Services & Resources
159. Maternal Health Services
160. Perinatal Services & Resources
161. Maternal Health Services
162. Perinatal Services & Resources
163. Maternal Health Services
164. Perinatal Services & Resources
165. Maternal Health Services
166. Perinatal Services & Resources
167. Maternal Health Services
168. Perinatal Services & Resources
169. Maternal Health Services
170. Perinatal Services & Resources
171. Maternal Health Services
172. Perinatal Services & Resources
173. Maternal Health Services
174. Perinatal Services & Resources
175. Maternal Health Services
176. Perinatal Services & Resources
177. Maternal Health Services
178. Perinatal Services & Resources
179. Maternal Health Services
180. Perinatal Services & Resources
181. Maternal Health Services
J.2 Care support and pathways participants relied on

Below are resources and services participants reported relying on to supplement the care they provide:

<table>
<thead>
<tr>
<th>Resources for PACPs</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Workers</td>
<td><a href="https://www.bcasw.org/">https://www.bcasw.org/</a></td>
</tr>
<tr>
<td>Midwives</td>
<td><a href="https://wwwbcmidwives.com/">https://wwwbcmidwives.com/</a></td>
</tr>
<tr>
<td>Pathways (care referral system)</td>
<td><a href="https://pathwaysbc.ca/info">https://pathwaysbc.ca/info</a></td>
</tr>
<tr>
<td>Connecting Pregnancy (Model of care for perinatal care)</td>
<td><a href="http://www.perinatalservicesbc.ca/health-professionals/professional-resources/system-planning/connecting-pregnancy">http://www.perinatalservicesbc.ca/health-professionals/professional-resources/system-planning/connecting-pregnancy</a></td>
</tr>
<tr>
<td>Emergency Room</td>
<td></td>
</tr>
</tbody>
</table>