



ORIGINAL ARTICLE

# Experiences of intensive home treatment for a mental health crisis during the perinatal period: A UK qualitative study

Luisa Rubio,  Billie Lever Taylor,  Nicola Morant and Sonia Johnson

Division of Psychiatry, University College London, London, UK

**ABSTRACT:** *Some women with severe perinatal mental health difficulties in England are cared for by acute home treatment services, known as Crisis Resolution Teams (CRTs), which provide short-term home-based treatment for adults experiencing a mental health crisis. Intensive home treatment has been trialed in a number of countries, but it is not known how well suited it is to the needs of perinatal women. This qualitative study aimed to explore how women and practitioners experience the provision of intensive home treatment for perinatal mental health problems. Semi-structured interviews were conducted with women who had received intensive home treatment in the perinatal period (n = 15), and focus groups were held with practitioners working in CRTs or in specialist perinatal mental health services (3 groups, n = 25). Data were analysed thematically. Women commonly found intensive home treatment problematic, experiencing it as intrusive and heavily risk-focused, with poor staff continuity and little tailoring to the perinatal context. However, women valued emotional support when provided, particularly when it had a perinatal focus, sometimes based on practitioners sharing their own experiences. Some women also appreciated avoiding hospital admission, but choice was often limited. Practitioners reported a lack of perinatal training among CRT staff and described difficulties tailoring treatment to perinatal women's needs. Currently, intensive home treatment, as offered by CRTs, may not be well suited to women with perinatal mental health difficulties. Findings suggest a need to develop community crisis responses that are better tailored to the needs of this population.*

**KEY WORDS:** *antenatal, crisis resolution teams, perinatal mental health, postnatal, qualitative.*

\***Correspondence:** Billie Lever Taylor, Division of Psychiatry, University College London, Division of Psychiatry, Maple House, 149 Tottenham Court Road, London, W1T 7NF, UK. Email: billie.taylor@ucl.ac.uk

**Funding:** The study was funded by the National Institute for Health Research (NIHR) under its Programme Grants for Applied Research (PGfAR) Programme (ESMI Programme: Grant Reference Number RP-PG-1210-12002). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR, or the Department of Health and Social Care.

**Declaration of conflict of interest:** The authors declare that they have no conflict of interest.

**Authorship statement:** All authors meet the International Committee of Medical Journal Editors definition of authorship listed here: (i) substantial contributions to the conception or design of the work, or the acquisition, analysis, or interpretation of data for the work; (ii) drafting the work or revising it critically for important intellectual content; (iii) final approval of the version to be published; (iv) agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved (ICMJE 2017). All authors are in agreement with the manuscript.

Luisa Rubio, MSc.

Billie Lever Taylor, PhD, DClinPsy.

Nicola Morant, PhD.

Sonia Johnson, MRCPsych, DM.

Accepted July 21 2020.

© 2020 The Authors. *International Journal of Mental Health Nursing* published by John Wiley & Sons Australia, Ltd on behalf of Australian College of Mental Health Nurses Inc.

This is an open access article under the terms of the Creative Commons Attribution License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited.

## INTRODUCTION

The risk of experiencing an acute psychiatric difficulty shortly after childbirth is elevated compared to other times in a woman's life (Kendell *et al.*, 1987; Munk-Olsen *et al.*, 2006). Perinatal mental health difficulties can have an enduring impact on the mother, on family relationships, and on infants' development (Howard *et al.*, 2014; Stein *et al.*, 2014). Suicide is the leading cause of direct maternal deaths in the year after pregnancy (Knight *et al.*, 2018).

The provision of specialist perinatal mental health care both in the UK and internationally is variable, and many perinatal women with severe psychiatric difficulties are supported by general mental health services which do not specialize in the perinatal period (Bauer *et al.*, 2014). UK provision of specialist care is more extensive than in most countries (Glangeaud-Freudenthal *et al.*, 2014), with a recent expansion of inpatient mother and baby units (MBUs; for women with acute difficulties) and community perinatal mental health teams (for women with moderate to severe difficulties). However, there remains relatively little in the way of specialist provision for women who experience an acute perinatal psychiatric crisis, but prefer to remain at home or do not require hospitalization. Community perinatal mental health teams do not usually have the capacity to offer the intensive treatment required in such cases, and women in this situation are commonly supported instead by generic crisis resolution teams (CRTs).

Crisis resolution teams, also known as home treatment teams or crisis resolution and home treatment teams, are multidisciplinary general mental health teams made up of psychiatrists, mental health nurses and other professionals and support staff. They offer rapid assessment and intensive (usually at least daily) home treatment to a range of individuals experiencing acute mental health crises. Support, typically offered for a period of around four weeks, can include symptom management, medication monitoring, practical help, psychoeducation, emotional support, and relapse prevention (Johnson, 2013). CRTs have been advocated as an alternative to hospitalization and as a means to enable early discharge from hospital, with the aim of reducing health service costs and increasing the acceptability of acute care to service users (MIND, 2011; Joint Commissioning Panel for Mental Health, 2012). It has been argued that treating people in their own homes may help practitioners work with people's wider support networks and may facilitate the development

of coping strategies that can be sustained in a real-life setting (Lloyd-Evans *et al.*, 2018).

Intensive home treatment has been introduced at various times in a range of countries, including Australia, Norway, Belgium, France, and the United States (Johnson, 2013). There is evidence that well-implemented intensive home treatment can reduce inpatient psychiatric admissions and is viewed by service users as preferable to hospitalization (Morant *et al.*, 2017; Murphy *et al.*, 2012). However, implementation of this model has been found to be variable (Lloyd-Evans & Johnson, 2014) with dilution of the original model, and concerns expressed by service users and carers about the quality of care provided (Care Quality Commission, 2015; Morant *et al.*, 2017).

It has been argued, both in the UK and internationally, that women diagnosed with perinatal mental health difficulties require care from specialist services, tailored to their needs in the perinatal context, rather than from generic services (Brockington *et al.*, 2017; Heron *et al.*, 2012; Millett *et al.*, 2018). Nevertheless, in a qualitative study of intensive home treatment for mothers with children of a range of ages, women generally reported positive experiences of care and preferred home treatment over hospital admission because they felt safer and better looked after at home (Khalifeh *et al.*, 2009).

While these findings suggest that intensive home treatment may be of value to mothers, to our knowledge no study has investigated how this type of support is experienced by perinatal women, despite the severe consequences that acute perinatal mental health difficulties can have for women, their infants, and wider families, if not treated appropriately.

The aim of this study was therefore to explore experiences of intensive home treatment among perinatal women. In particular, we sought to investigate whether crisis teams meet women's needs and identify any perceived barriers or facilitators to delivering satisfactory care in this context. We also included the views of mental health practitioners working in CRTs and in specialist perinatal mental health services to enable their perspectives to be taken into account and explore ways of improving care provided.

## METHOD

This study was part of a wider qualitative study (the 'STACEY' study), exploring experiences of a range of services treating women with perinatal mental health difficulties. The STACEY study was itself part of a

mixed-methods programme of research called Effectiveness of Services for Mothers with Mental Illness (ESMI) [<https://www.kcl.ac.uk/ioppn/depts/hspr/research/ceph/wmh/projects/a-z/esmi>].

## Participants

### *Women*

Fifteen women from the wider STACEY sample (of 52 women in total) were included in this study because they had accessed a CRT during or after their most recent pregnancy. These fifteen women were recruited from seven diverse NHS healthcare providers across England. For the wider study, purposive sampling was used to obtain diversity of diagnosis and sociodemographic background. Additional inclusion criteria required that women were aged 16 or over; English-language speakers; and had a baby aged 6–9 months old at the time of interview. Eligible women were initially approached by a member of their mental health team, and those who expressed willingness to participate were contacted by a researcher to provide further information about the study. Interviews were arranged for those who agreed to take part, and informed written consent was obtained. Researchers were only informed of women interested in participating, and therefore, it was not possible to determine how many women declined. In total, we attempted to contact 64 women and 52 took part.

### *Practitioners*

As part of the wider STACEY study, focus groups were also carried out with practitioners across a range of services. Practitioners were recruited by contacting relevant services and advertising the study with their support. Inclusion criteria required that practitioners had experience of supporting women diagnosed with perinatal mental health problems.

In total, 10 focus groups were carried out with 95 practitioners. Of these, 25 practitioners from 3 focus groups were included in the current study because they all gave their views on CRT care in the perinatal period. One of the 3 focus groups from which we have included data consisted of 11 practitioners who all worked in a single CRT but varied in their professional roles (FG1). The second focus group consisted of a mixed group of 8 mental health and maternity practitioners, of whom 2 were CRT practitioners. These 2 CRT practitioners were asked about their views of CRTs during the focus group and their responses were

analysed and included (FG2). The third focus group consisted of 12 perinatal specialist clinicians from different teams across an NHS healthcare provider who were asked, among other topics, for their views on CRTs (FG3). All practitioners provided informed written consent.

## Data collection

Data collection took place between June 2015 and February 2017.

### *Women*

A semi-structured interview guide was developed by the research team and was adapted based on feedback from a perinatal service user and carer panel. It was piloted with five women with experience of using perinatal mental health services, including crisis resolution teams. Interviews lasted approximately one hour, and participants were usually interviewed in their own homes.

The interview guide was designed to explore women's views of all the services they had accessed for their perinatal mental health in relation to their most recent pregnancy. Women were asked about topics including their experience of accessing services; information, choice, and decision-making; views of service delivery and perceived gaps; communication between services; involvement of family members; and therapeutic relationships. In cases where interviews covered views of other services as well as CRTs, only the CRT-relevant data were analysed for this study.

### *Practitioners*

Preliminary anonymized findings from interviews with women were presented to practitioners in focus groups who discussed them in relation to their own experiences of supporting women with perinatal mental health difficulties. Where focus groups included discussion of other services as well as CRTs, only CRT-specific data were analysed for this study. Focus groups lasted approximately one hour.

All focus groups ( $n = 3$ ) and the majority of interviews ( $n = 13$ ) were conducted by the second author (who is a mother, researcher, and clinical psychologist). The remaining two interviews were conducted by a member of the wider study team (a mother, qualified social worker, and researcher), and by a lived experience researcher from the perinatal service user and carer panel.

## Data analysis

Interviews and focus groups were audio-recorded, transcribed, anonymized, and imported into NVivo 11 qualitative analysis software<sup>1</sup>. Two separate datasets were created: one for women and one for practitioners. Data were analysed by the first author (a researcher studying for an MSc in Clinical Mental Health Sciences) using thematic analysis (Braun & Clarke, 2006). Initial detailed reading of transcripts enabled the formation of preliminary codes, which were then developed into themes using a combination of inductive and deductive approaches. The coding frame was elaborated and adapted through a cyclical process of reading, coding, and exploring the patterning of data. To enhance validity, a second researcher (also an MSc student) independently coded a selection of transcripts, and emerging themes were discussed between the researchers, as well as the wider study team, enabling the coding frame to be developed collaboratively. Draft findings were also reviewed by members of the service user and carer panel and adapted based on their feedback.

## RESULTS

### Participant characteristics

Characteristics of participating women and practitioners are shown in Tables 1 and 2. Women's average age was 31 years, ranging from 19 to 39. Around half were White British, and depression was the most common diagnosis. Three fifths of women had utilized an inpatient service (acute ward or MBU) as well as a CRT. All practitioners were female, and around half were White British.

### Findings

We identified four key themes in the data: (i) frequent home visits and continuity of care; (ii) brief risk-focused support; (iii) knowledge and understanding of the perinatal context; and (iv) choice in the context of limited specialist service availability. Overall, while some perinatal women found intensive home treatment valuable, a clear majority felt it was intrusive, impersonal, and not well tailored to the perinatal context. While we comment below on differences in women's views according to sociodemographic or other characteristics where possible, overall similar negative views of CRTs were expressed by women from various sociodemographic backgrounds. Practitioner views

overlapped with women's views, highlighting issues relating to difficulties with providing generic home treatment in the perinatal period, and problems relating to lack of staff expertise.

#### *Frequent home visits and continuity of care*

Women usually reported that they had received a brief period of intensive home treatment in the form of daily face-to-face visits from professionals. In the context of managing a new baby, women commonly found the high frequency of these daily visits problematic, describing them as intrusive, disruptive to routines, and overwhelming.

'It was kind of like an extra stress if I'm honest... It was just a bit like, oh but baby's had a bad night and I haven't even slept but I still have to get up and see this person'.  
(Mother 3)

Women said that professionals visited at inconvenient times, often without warning, or gave wide time windows for visiting and sometimes missed appointments. For some women, visits from crisis team staff were therefore experienced as a source of stress rather than support.

'They couldn't tell me when they were going to come and I had a newborn baby and they would rock up whenever, say it might be time to feed or...eat your own dinner...There would be two or three of them and they would...just get in the way...It was worse having them than not having them'.  
(Mother 9)

Continuity of care was highly valued, and women disliked that intensive home treatment usually involved different professionals at each visit, especially as many women feared opening up about their difficulties in case they were judged to be unfit mothers. Although this was common among women with partners, it was particularly emphasized by the three women who lived without a partner, including one who felt that despite building some sort of relationship with CRT staff, their visits ended abruptly which led to feelings of vulnerability as a single mother with no continuity of support. Participants commented that their wider maternity care often already lacked consistency and that intensive home treatment could exacerbate their sense of being overwhelmed by unfamiliar professionals, rather than helping them feel safe opening up to a known and trusted individual.

'It's very difficult when you've got a different person coming to your house every day. "How are you today?" "Well I don't know you from Adam so-"  
(Mother 5)

**TABLE 1:** Women's characteristics (n = 15)

Characteristics	Category	N
Age	19–25	4
	26–32	3
	33–39	8
Ethnicity	White British	8
	Black African	2
	Black Caribbean	2
	Mixed – Black	2
	African/ White	1
Primary diagnosis	White Other	1
	Depression	7
	Bipolar disorder/psychosis	3
	Personality disorder	2
	Anxiety	2
Time of CRT input	Schizophrenia	1
	Antenatal	1
	Postnatal	14
Previous mental health service use	Yes	11
	No	4
Social service input	Yes	8
	No	7
Psychiatric inpatient admission during perinatal period	Acute ward/crisis house	6
	MBU	3
	MBU and acute ward	1
	No admission	5
Living with partner	Yes	12
	No	3
Number of children	1	9
	2	5
	3	1
Highest educational Qualification	Postgraduate	6
	National diploma/certificate	4
	A-level	2
	GCSE	2
	No formal qualifications	1

Nevertheless, one participant acknowledged that home treatment visits did at least give her 'a reason to kind of get out of bed and kind of get up and get washed and dressed' (Mother 3). A few liked the 24–7 availability of CRTs or described regular daily visits as containing and motivating. Women particularly valued practitioners making an effort to fit around their daily routines or finding ways to offer at least some continuity, for example by limiting the number of different practitioners involved. Positive experiences seemed to be more common among women who had intensive home treatment without also having an admission to hospital.

**TABLE 2:** Professionals' characteristics (N = 25)

Characteristics	Category	N
Gender	Female	25
	Male	0
Ethnicity	White British	10
	Black African	8
	Black Caribbean	1
	Asian	2
	White Other	4
Role and focus group composition		
Focus group 1 (CRT practitioners)	Psychiatrist	4
	Community psychiatric nurse	6
	Community support worker	1
Focus group 2 (mix of services including 2 CRT practitioners)	Community psychiatric nurse/student nurse	2
	Psychiatrist	5
Focus Group 3 (specialist perinatal practitioners)	Perinatal mental health nurse	6
	Student	1
Average years working in current role	CRT practitioners	7
	Specialist perinatal	9
Average years working with women with perinatal mental health difficulties	CRT practitioners	9
	Specialist perinatal	8

'I felt very supported by the [CRT] because I had in my head that they would be there every day...They would be very flexible with times, like they'd say, "We can't see you then, when's convenient for you?"'

(Mother 2)

'They managed to provide that consistency of me seeing a handful of people repeatedly. That was really good, because you could form some kind of relationship with them'.

(Mother 11)

CRT practitioners expressed a desire to provide women with greater choice and flexibility regarding home visits, and better consistency of care. However, the unpredictability of their working environment, high caseloads, and challenges with shift patterning meant they felt this was not always possible. Nevertheless, some practitioners did suggest that special provisions for new mothers might be feasible and of value given their unique needs.

'There's no specialised perinatal service delivered for women having home treatment. They're just treated like everybody else in that they'll be seen by whichever practitioner is on in that day...but I can see for that group it would matter so much more wouldn't it to

have the same person that you were building a rapport with. . .

. . . Maybe there is an effort that could be made to highlight that group to only have one or two people involved and over shift patterns you could maybe do that'. (FG2, CRT Community Psychiatric Nurse)

#### *Brief, risk-focused support*

Emotional support was seen by women as the most valuable aspect of intensive home treatment. They appreciated being listened to by staff and receiving advice and encouragement. Some also wanted practical support and advice caring for their babies in the context of their mental health difficulties. However, overall women felt that the provision of meaningful support was compromised by brief visits that lacked depth and were heavily focused on risk management. This could make women feel that crisis teams offered an impersonal service, especially when staff were also perceived to lack warmth.

'I just felt very much like they were just there for, sort of, risk management, just to, sort of, really keep tabs on me. . . No, sort of, actual, no meaningful kind of support, practically or anything'. (Mother 12)

'There's been a few of them that have been really understanding and helpful and then there's been a few of them that. . . I can't connect with. They just seem a bit cold and like, yes, I haven't been able to connect with them. . . They just seemed like, yes okay you're here, baby's okay. Okay I'm going, kind of thing'. (Mother 3)

The perceived emphasis on risk and a lack of more meaningful support paradoxically meant some women were fearful of being honest with crisis team professionals about their feelings and were therefore less likely to engage or disclose relevant information, in case this resulted in hospitalization or in their babies being taken away. These concerns were very common among women who also had social services input, and who were often living in challenging social contexts.

'Every time [the crisis team] came around I just said I was all right. I was better, basically. Even though I wasn't. I just had to lie to them to get them away from me'. (Mother 6)

Although CRT practitioners were themselves aware that perinatal women might hesitate to disclose their feelings, specialist perinatal practitioners voiced concerns that, despite their heavy focus on risk, crisis team clinicians might in fact lack the expertise to identify specific perinatal risks.

'I find [staff in generic services like CRTs] are very quick to say, "No, this person's fine, they don't really need the support, they don't need the help" and those things get missed'. (FG3, Perinatal mental health nurse)

#### *Knowledge and understanding of the perinatal context*

Although women usually connected their difficulties to the transitions involved in having a baby, they felt CRT staff did not always recognize the significance of this, only acknowledging their babies when checking risk, and providing little additional support tailored to motherhood and the perinatal context.

'I feel like a lot of this has been struggling to adapt to the changes [of having a baby]. . . I don't think there was that specific side of things addressed, no. It's more of a generic service'. (Mother 11)

Some women felt that a lack of perinatal expertise or understanding of the perinatal context among crisis team practitioners led them to offer unhelpful, generic or contradictory advice. Women also had concerns about the quality of advice given about medication in the perinatal period.

'The fact that they were asking the same sort of questions over again. . . just made me feel they didn't have a lot of experience of you know, mums and babies. . . I wasn't feeling confident, convinced about their suggestions of what medication I could take'. (Mother 12)

Furthermore, while partners and wider family members were often perceived to be influential in relation to a woman's perinatal mental health, experiences of family involvement were variable. Although CRT visits took place in women's homes, offering greater opportunities for family members to be involved and wider social networks to be considered, some women felt that the wider context was not appropriately addressed. This was a prominent shortfall reported by women who generally had a more positive CRT experience.

'When [the clinicians] came around it was literally just to talk to me, they weren't sort of interested in anybody else'. (Mother 24)

Practitioners working in CRTs admitted that they sometimes struggled to manage visits in the context of a hectic family environment and to involve families without compromising women's privacy.

'You home visit somebody. . . you can have three children running around the house. You can't even have a

conversation, everyone listening to what you're trying to [say]' (FG2, CRT Community Psychiatric Nurse)

CRT clinicians also admitted to finding women's desire to focus on their babies challenging. They tended to interpret mothers' reluctance to engage with them as a failure to acknowledge the importance of their mental health difficulties, rather than as an indication that the support offered might be problematic.

'Half the time [mothers] don't want to focus on their own mental health...they want to talk about the baby...We were saying that there was a problem and we were wanting to pin her down into another day to see her and she didn't seem to think that was important'. (FG1, CRT Community Psychi Nurse)

Nevertheless, in some cases CRT staff managed to draw on their own experiences of parenting to empathize with women and tailor practical and emotional support to them. Women and practitioners alike noted that this helped establish trusting therapeutic relationships.

'[The crisis team clinician] was a mum, and she was very lovely, and she understood my situation really well'. (Mother 7)

'One thing I found useful...is just normalising things. You know, using your own experiences to say..."We're not perfect, it takes time to get to know your baby"'. (FG1, CRT Nurse)

Crisis Resolution Teams practitioners voiced a desire for more training about perinatal mental health, as they felt this was lacking within their current training. They found conducting joint visits with health visitors or midwives useful, allowing different types of expertise to be combined. Some specialist perinatal practitioners also suggested that CRT staff could benefit from 'outreach' training from specialist perinatal practitioners or that, with extra resources, perinatal teams could respond to crises themselves, reducing the need for CRTs to engage with perinatal populations.

#### *Choice in the context of limited specialist service availability*

Despite difficulties in tailoring intensive home treatment to the perinatal period, some women were pleased to have the option to avoid hospital admission.

'They wanted me to go to [an MBU] and I said, "No way"...[The MBU] is miles from here and I just thought, what a start in life is that really?' (Mother 8)

Other women, however, wanted access to specialist perinatal services like MBUs rather than home treatment. This could be because they felt they needed additional support with their baby and to be removed from their home context.

'I said I really want to go into [an MBU]. And [the community team] said "no, I don't think you need to go into one of those"...What I felt like was I can't cope with my normal life...I need to get away from it'.

(Mother 11)

Some women reported feeling that they had little choice, especially where there was no local MBU, so home treatment was presented as the only alternative to a general inpatient admission and separation from their baby. Overall, women expressed a range of views about service preferences, but it was clear that variability in local provision of specialist perinatal mental health support limited the choices available to them.

Practitioners acknowledged difficulties relating to a lack of local specialist perinatal services. In areas without a local MBU, CRT practitioners described feeling under increased pressure to treat women at home in order to avoid admission to a general psychiatric inpatient ward.

'We would, you know, do our utmost to keep people at home if an acute bed is the only option...I think when we're in that situation obviously our anxieties get raised'. (FG1, CRT Nurse)

Women valued jointly planning a gradual reduction in intensive home treatment. However, discharge experiences were variable, with some women reporting an abrupt ending of care without follow-up, and others feeling they were left suspended between services. CRT clinicians expressed frustration about pressures to discharge women to free up caseloads, especially as they were often unable to follow up women post-discharge to ensure they had accessed further support. Some highlighted chaotic referral processes and poor communication between services. They also felt uncertain where best to signpost women following CRT care when specialist perinatal support was not available locally.

## DISCUSSION

Our qualitative research findings suggest that women with perinatal mental health difficulties do not always experience intensive home treatment as being well tailored to their needs. While a few women valued daily

home visits from professionals and liked the 24/7 availability of CRTs, a clear majority experienced care as intrusive and disruptive, with inconvenient visiting times and a lack of staff continuity. Although lack of continuity and ill-timed visits are frequent complaints in the wider literature on CRTs, daily visits are often valued outside the perinatal phase (Carpenter & Tracy, 2015; Morant *et al.*, 2017). Thus, consideration of the timing, predictability, and organization of visits may be especially important in the perinatal period, when women are struggling to adjust to life with a new baby, disturbed sleep patterns and fatigue (Howard & Hunt, 2008).

Specialist perinatal practitioners harboured concerns that CRT staff might not be sufficiently attuned to judging risk specifically in the perinatal period. Women meanwhile described CRT visits as too risk-focused, with insufficient emphasis on emotional support. This reinforces previous literature on experiences of CRTs (Carpenter & Tracey, 2015) and contributed to some women feeling scrutinized, unable to open up, and fearful that they would be judged to be unfit mothers. Such concerns, coupled with seeing different professionals each visit, were particularly acute for single mothers and those with social services input, many of whom also described living in challenging and sometimes traumatic contexts. Fear of being deemed a 'bad' parent and of having their children removed is a pervasive issue for mothers (Megin-Viggars *et al.*, 2015). Such issues can be especially salient for those living in difficult social circumstances (Zacharia *et al.*, 2020), and it has been pointed out that women with traumatic pasts can find mental health services disempowering and even re-traumatizing if not delivered in a way that is sensitive to their needs (Department of Health and Social Care, 2018). It was notable though in our research that negative views of CRTs were expressed by women from a range of sociodemographic backgrounds.

Lack of specialist perinatal expertise or tailoring was a recurrent theme expressed by both women and practitioners, though staff who can draw on their own parenting experiences may manage this better. This echoes findings from other literature, which suggest that generic mental health services do not always recognize the role and identity of motherhood in women's lives and may not have the resources or capacity to deliver the tailored care perinatal women require (Department of Health & Social care, 2018; Millett *et al.*, 2018). Hospital admission to a specialized MBU was sometimes preferred over home treatment to allow women to access specialist support and respite. MBUs

enable women to be co-admitted full-time with their babies and in contrast with acute psychiatric wards, are often experienced positively by women because of staff members' specialist expertise and the practical support women receive caring for their infants (Griffiths *et al.*, 2019). Therefore, unlike acute psychiatric wards, which are often a last resort for service users, admission to an MBU may be viewed as preferable to remaining at home for some women.

Nevertheless, as with other CRT populations, some women clearly valued staying at home (Carpenter & Tracy, 2015), with an additional benefit in this phase of life being proximity to the other parent and wider support network. It was conspicuous, however, that CRTs did not always involve women's support networks or acknowledge the relevance of their wider familial and social contexts. The importance of approaching perinatal mental health not just at an individual level, but with reference to wider social and cultural factors and the need to be sensitive to factors such as socio-economic status, gender, and identity, is increasingly emphasized in service policy guidance (e.g. Department of Health and Social Care, 2018). Overall, our findings suggest that a specialist perinatal crisis response in the community, tailored to the needs of perinatal women and grounded in an understanding of the role of broader social influences, appears to be an important and largely unmet need.

### Clinical implications

This study suggests the need to tailor generic service delivery to the perinatal context. Some beneficial changes may be feasible without large-scale changes in services. For example, especially in a reasonably well-resourced CRT, it may be feasible to offer greater flexibility and choice (e.g. around appointment times and frequency of face-to-face visits) to fit mothers' needs. Home visits could be conducted primarily by one or two key workers who are well suited to working with perinatal women (because of specialist training or their own experience as parents). This would improve continuity of care and offer more opportunities for developing the empathetic, normalizing therapeutic relationships that many women value. In addition, greater consideration could be given to developing peer support networks or signposting towards existing local initiatives for new parents, as well as to working with (in) women's wider familial and social contexts.

A striking finding from both service user and staff data was a perceived need for a more tailored



community response to perinatal mental health crises. The value of specialist expertise and tailoring when treating perinatal distress has been acknowledged in other research (Lever Taylor *et al.*, 2020). This is potentially achievable in a number of ways, and research evidence is needed regarding the most effective approach, preferably based on co-production principles to ensure service users themselves are involved in co-designing services. One approach is delivery of additional perinatal training for generic mental health staff, such as CRT practitioners, with potential foci including sensitive conduct of perinatal mental health and risk assessments, understanding of the needs of perinatal women and babies within their specific socio-cultural context, and greater awareness of the importance of family inclusion in treatment. While this was frequently proposed in our study, change in clinical practice probably requires more than a brief period of training.

Other approaches to implementing more tailored care within generic services could include having specialist workers or perinatal champions within CRTs, linking with perinatal services, and developing protocols for joint working between CRTs and both specialist perinatal teams and general maternity services.

Some specialist practitioners also suggested there may be benefit from increasing resources for specialist perinatal mental health services. This would enable them to offer enhanced provision to support women in a perinatal crisis at home, thus reducing the need for generic CRTs to step in. However, the feasibility of this would need to be established. Indeed, more research is required, both to identify and evaluate any innovative models of care currently in existence nationally or internationally, and to develop, evaluate, and implement new models of care.

### Study limitations

While this is the first study to specifically explore experiences of CRT support among perinatal women, its limitations should be considered. Firstly, while small samples can achieve theme saturation in qualitative studies (Guest *et al.*, 2006), recruitment via clinical teams means the service user sample likely under-represents women who were less engaged with services. We were also not able to include women who did not speak English, who may face unique challenges with mental health care provision. The practitioner sample may likewise under-represent those less interested in perinatal mental health. Findings may not apply to all

UK CRT teams, especially given their known variability, and all practitioners were female (though this may partly reflect a gender imbalance in services). Additionally, while our focus groups included a variety of practitioners, the methodology can sometimes limit the expression of views that may conflict with those of colleagues, particularly between practitioners at different seniority levels. Finally, as this study was part of a wider project on women's entire pathway of care during the perinatal period, the length of time in interviews devoted specifically to discussing CRTs was sometimes restricted. Nevertheless, rich CRT-specific information was obtained.

### CONCLUSION

Our findings suggest a need to better tailor crisis care in the community to perinatal women. Intensive home treatment, offered by generic services, may not currently be well suited for women with perinatal mental health difficulties. This is important, given the impact that severe mental health difficulties can have on a mother, baby, and wider family. We argue that improved service provision could potentially be achieved through enhanced collaboration and coordination with specialist perinatal services, greater use of co-production in designing services, specialist workers in CRTs who lead on perinatal mental health, expansion of perinatal services to allow them to offer more intensive treatment themselves, and improved training for CRT professionals.

### RELEVANCE TO CLINICAL PRACTICE

To our knowledge, this is the first published study of perinatal women's experiences of intensive home treatment. It is pertinent to current policy priorities in the UK to improve services for perinatal mental health difficulties (NHS, 2019) and to improve CRT implementation (Lloyd-Evans *et al.*, 2016). It is also of value internationally, suggesting the need to tailor generic mental health service delivery to the perinatal context. Based on our findings, we have proposed a number of potential changes to clinical practice that could help enhance women's experiences of care.

### ACKNOWLEDGEMENTS

The authors are very grateful indeed for the advice and support received from the Perinatal service user and carer Advisory Group (PAG), and from the wider

ESMI study team led by Prof Louise Howard. The study team would also like to thank the women and practitioners who gave up their time to take part in the study.

## ETHICAL APPROVAL

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards.

## INFORMED CONSENT

Informed written consent was obtained from all individual participants included in the study.

## Note

<sup>1</sup> In addition to the 15 included interviews with women, 2 further interviews were carried out but were accidentally not recorded and therefore were not included in this analysis.

## REFERENCES

- Bauer, A., Parsonage, M., Knapp, M., Lemmi, V. & Bayo, A. (2014) The costs of perinatal mental health problems. Centre for Mental Health. <http://eprints.lse.ac.uk/59885/>. Accessed: 31 July 2019.
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2), 77–101.
- Brockington, I., Butterworth, R. & Glangeaud-Freudenthal, N. (2017). An international position paper on mother-infant (perinatal) mental health, with guidelines for clinical practice. *Archives of Women's Mental Health*, 20 (1), 113–120.
- Care Quality Commission (2015). Right here, right now-people's experience of help, care and support during a mental health crisis. <https://www.scie-socialcareonline.org.uk/right-here-right-now-peoples-experiences-of-help-care-and-support-during-a-mental-health-crisis/t/all1G000000AwOLbIAN> Accessed: 16 October 2018 .
- Carpenter, R. A. & Tracy, D. K. (2015). Home treatment teams: what should they do? A qualitative study of patient opinions. *Journal of Mental Health*, 24 (2), 98–102.
- Department of Health and Social Care (2018). The Women's Mental Health Taskforce, final report. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/765821/The\\_Womens\\_Mental\\_Health\\_Taskforce\\_-\\_final\\_report1.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765821/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf). Accessed: 08 June 2020.
- Glangeaud-Freudenthal, N. M. C., Howard, L. M. & Sutter-Dallay, A.-L. (2014). Treatment - mother-infant inpatient units. *Best Practice & Research: Clinical Obstetrics & Gynaecology*, 1, 147–157.
- Griffiths, J., Taylor, B. L., Morant, N. *et al.* (2019). A qualitative comparison of experiences of specialist mother and baby units versus general psychiatric wards. *BMC Psychiatry*, 19 (1), 401.
- Guest, G., Bunce, A. & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18 (1), 59–82.
- Heron, J., Gilbert, N., Dolman, C. *et al.* (2012). Information and support needs during recovery from postpartum psychosis. *Archives of Women's Mental Health*, 15 (3), 155–165.
- Howard, L. M. & Hunt, K. (2008). The needs of mothers with severe mental illness: a comparison of assessments of needs by staff and patients. *Archives of Women's Mental Health*, 11 (2), 131.
- Howard, L. M., Molyneaux, E., Dennis, C. L., Rochat, T., Stein, A. & Milgrom, J. (2014). Non-psychotic mental disorders in the perinatal period. *The Lancet*, 384 (9956), 1775–1788.
- Johnson, S. (2013). Crisis resolution and home treatment teams: an evolving model. *Advances in Psychiatric Treatment*, 19 (2), 115–123.
- Joint Commissioning Panel for Mental Health (2012). Guidance for commissioners of perinatal mental health services. <http://www.jcpmh.info/wp-content/uploads/jcpmh-perinatal-guide.pdf> Accessed: 10th February 2017.
- Kendell, R. E., Chalmers, J. C. & Platz, C. (1987). Epidemiology of puerperal psychoses. *The British Journal of Psychiatry*, 150 (5), 662–673.
- Khalifeh, H., Murgatroyd, C., Freeman, M., Johnson, S. & Killaspy, H. (2009). Home treatment as an alternative to hospital admission for mothers in a mental health crisis: a qualitative study. *Psychiatric Services*, 60 (5), 634–639.
- Knight, M., Draper, E. S. & Kurinczuk, J. J. (2018). *Key messages from the UK Perinatal Confidential Enquiry into term, singleton, intrapartum stillbirth and intrapartum-related neonatal death 2017* (pp. 5–21). Oxford: National Perinatal Epidemiology Unit, University of Oxford.
- Lloyd-Evans, B. & Johnson, F. (2014). Crisis resolution teams: how are they performing?. *Mental health today* (Brighton, England), pp. 18–19.
- Lloyd-Evans, B., Bond, G. R., Ruud, T. *et al.* (2016). Development of a measure of model fidelity for mental health Crisis Resolution Teams. *BMC Psychiatry*, 16 (1), 427.
- Lloyd-Evans, B., Paterson, B., Onyett, S. *et al.* (2018). National implementation of a mental health service model: a survey of crisis resolution teams in England. *International Journal of Mental Health Nursing*, 27 (1), 214–226.
- Megnin-Viggars, O., Symington, I., Howard, L. M. & Pilling, S. (2015). Experience of care for mental health problems in the antenatal or postnatal period for women in the UK:

- a systematic review and meta-synthesis of qualitative research. *Archives of Women's Mental Health*, 18 (6), 745–759.
- Millett, L., Taylor, B. L., Howard, L. M., Bick, D., Stanley, N. & Johnson, S. (2018). Experiences of Improving Access to Psychological Therapy Services for Perinatal Mental Health Difficulties: a Qualitative Study of Women's and Therapists' Views. *Behavioural and Cognitive Psychotherapy*, 46 (4), 421–436.
- MIND (2011). Listening to experience: an independent inquiry into acute and crisis mental healthcare. [https://www.mind.org.uk/media/211306/listening\\_to\\_experience\\_web.pdf](https://www.mind.org.uk/media/211306/listening_to_experience_web.pdf) Accessed: 13 June 2017.
- Morant, N., Lloyd-Evans, B., Lamb, D. *et al.* (2017). Crisis resolution and home treatment: stakeholders' views on critical ingredients and implementation in England. *BMC Psychiatry*, 17 (1), 254.
- Munk-Olsen, T., Laursen, T. M., Pedersen, C. B., Mors, O. & Mortensen, P. B. (2006). New parents and mental disorders: a population-based register study. *JAMA*, 296 (21), 2582–2589.
- Murphy, S., Irving, C. B., Adams, C. E. & Driver, R. (2012). Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Reviews*, 12, 1465–1858.
- Stein, A., Pearson, R. M., Goodman, S. H. *et al.* (2014). Effects of perinatal mental disorders on the fetus and child. *The Lancet*, 384 (9956), 1800–1819.
- Zacharia, A., Taylor, B. L., Sweeney, A., Morant, N., Howard, L. M. & Johnson, S. (2020). Mental Health support in the perinatal period for women with a personality disorder diagnosis: a qualitative study of women's experiences. *Journal of Personality Disorders*, 1–16. Epub ahead of print. [https://doi.org/10.1521/pedi\\_2020\\_34\\_482](https://doi.org/10.1521/pedi_2020_34_482)