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"There's very little that you can do other than refer them to the doctor if you think they've got postnatal depression": Scoping the potential for perinatal mental health care by community pharmacists

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ABSTRACT

Background: Twenty percent of women in the UK develop perinatal mental health (PMH) problems, which have widespread effects on maternal and child health. Community pharmacists are ideally placed to identify PMH problems and refer to other trained healthcare professionals.
Objective: This study explored community pharmacists' attitudes, current counselling practices, and barriers to providing mental health advice to perinatal women.
Methods: A qualitative focus group study was performed virtually with community pharmacists (n = 11), working in urban settings across London. A topic guide was used to cover current counselling practice, barriers to and confidence in counselling women, and thoughts on potential pharmacist-led perinatal mental health services. The focus groups were recorded, transcribed, and analysed using thematic analysis.
Results: Three themes were identified: *Doing* Mental Health Care; Willing, but Unable; and Introspection and reflection, which were related through a central organising concept of 'Perinatal mental health care as a new frontier for community pharmacy'. It was found that while community pharmacists provide mental health advice to perinatal women and their partners, they lacked confidence, which was related to a lack of knowledge and inadequate training opportunities. Organisational barriers were identified including a lack of a formal referral pathway to existing mental health services and other trained healthcare professionals. Perceptions of opportunities and recommendations for service improvement and change were also garnered.
Conclusion: This study demonstrates community pharmacists have a potential role within community mental healthcare in identification of PMH problems and providing appropriate advice and support. Upskilling community pharmacists in mental health should be considered to increase knowledge and confidence while formal referral pathways to other trained healthcare professionals and existing services should be established and made available to pharmacists.

1. Introduction

Community pharmacists are accessible healthcare professionals and

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well-positioned to provide advice to pregnant and postpartum women. However, their role in perinatal mental health (PMH) care has not been defined. PMH problems are those which occur during pregnancy or in the first year following the birth of a child and encompass a wide range of conditions including anxiety, depression, and postnatal psychotic disorders which are often preceded by similar problems before pregnancy, many beginning in adolescence.[1] Twenty percent of women in the United Kingdom (UK) develop PMH problems,[2] which have wide-ranging effects on maternal and child health including an increased risk of psychological and developmental disturbances in children.[3] The increasing recognition of the burden of PMH problems has resulted in strategic investment by NHS England, with the aim of providing access for women with moderate to severe PMH problems to community care from preconception to 24 months post birth.[4] However, in almost half of the UK, women have no access to community based specialist services.[5]

Abbreviations

PMH	Perinatal mental health
CPCS	Community Pharmacist Consultation Service
UK	United Kingdom
GP	General Practitioner ('Family Doctor')
MHFA	Mental Health First Aid

As recommended by clinical guidance in England, all women are invited to a structured postnatal check at six to eight weeks post birth as part of routine care which includes identifying postnatal mental health problems including postnatal depression.[6] A large population study of postnatal health checks in the UK reported that 2 in 10 women did not have a consultation at the time of the planned check, and consultations were less likely in women living in deprived areas and teenage women.[7] Furthermore, PMH services have been found to be difficult to access and navigate by ethnic minority women in the UK.[8] Together with the impact of the COVID-19 pandemic on access to primary care services, opportunities to identify mental health problems in perinatal women may be missed.[9–13] There is an urgent need to develop new strategies to identify PMH problems and deliver evidence-based interventions, to positively impact mental health during and after pregnancy.

Community pharmacies are easily accessible in England, particularly in areas of high deprivation[14] and are ideally positioned to identify PMH problems through their conversations with women and their partners. The community pharmacist has an increasing role in mental health and wellbeing,[15,16] the importance of which was highlighted in the response to the impact of the COVID-19 pandemic.[17] Indeed, emerging research suggests a role for community pharmacists in PMH promotion. For example, a qualitative study in Australia found most community pharmacists highlighted their role in recognising perinatal depression and providing medication related support. However, barriers to service provision were reported which included inadequate training, and a lack of established referral systems.[18] There may be a role for community pharmacists in the early recognition of PMH problems and referring to other healthcare professionals and existing services. However, there is a paucity of studies exploring pharmacists' experiences and perspectives in providing mental health advice to perinatal women. This study aimed to explore community pharmacists' attitudes, current counselling practices, and barriers to providing mental health advice to perinatal women.

2. Methods

A qualitative research design was employed, utilising focus groups, to facilitate the exploratory nature of the proposed research.[19] Ethical approval for the study was obtained from King's College London (ref: LRS/DP-20/21–22603).

2.1. Recruitment, setting, and participants

Participants were identified through emails circulated to community pharmacies. Community pharmacists who were interested in taking part contacted the research team and written consent was obtained. Inclusion criteria required practising community pharmacists, willing and able to provide informed consent. Eleven participants were recruited (male: n = 3; female: n = 8), who worked in urban areas in London. Participants worked in both independent pharmacies (n = 6) and as part of large pharmacy multiples (n = 5) and ranged in experience from 7 to 40 years (Table 1).

2.2. Data collection

Three focus groups (n = 4, n = 4, n = 3) were conducted virtually via Microsoft Teams (version 1.5.00.17261) in late-October 2021, at times convenient to participants (evenings, after work had finished), and were facilitated by members of the research team (SL, AF). Participants were asked to confirm consent and that they were happy with the focus groups being recorded.

The focus group topic guide was developed specifically for the study drawing on the expertise of the research team, who later worked together to refine iterations of it. The topic guide facilitated discussion on current practice, attitudes, confidence in providing mental health advice, and potential PMH service provision. The audio data were downloaded from Microsoft Teams and uploaded to a professional transcription company to be transcribed using intelligent transcription into Microsoft Word (version 16.63.1). All identifiable information was removed during the transcription process to maintain anonymity of the participants. Rigorous checks were carried out to ensure there were no discrepancies between the transcribed data and the original recordings. This was done by listening back to the original audio and checking the accuracy of the verbatim transcript.

2.3. Data analysis

Data were analysed using thematic analysis,[20] which involves six phases including: familiarisation with data, generation of initial codes, searching for themes, reviewing themes, naming themes, and creating

Table 1
Focus group participant characteristics.

Focus group	Participant	Years of experience in community practice	Type of pharmacy	Area
1	F1	7	Independent	North-west London
	F2	9	Multiple	North-west London and Hertfordshire
	F3	10	Multiple	North-west London
	M1	35	Multiple	North-west London
2	F1	10	Independent	South-east London
	F2	28	Multiple	South London
	F3	40	Independent	North London
	M1	40	Independent	North London
3	F1	40	Multiple	North-west London
	F2	8	Independent	North-west London
	M1	20	Independent	North London

the final report. The data were independently coded by two of the research team (MRR and ACF), who discussed codes together and grouped codes which were supported by similar data. Discrepancies between codes were discussed and amendments made before codes were grouped into themes. An iterative process was followed, with continued reference to the original data. Themes and sub-themes were refined by members of the research team (MRR, ACF, JW, SAS), and subsequently provided with appropriate, explanatory theme names. The themes were related through a central organising concept.[21]

3. Results

Three main themes were identified across the dataset: 1) *Doing*[2] Mental Health Care; 2) Willing, but Unable; and 3) Introspection and reflection. Each theme had two sub-themes (Table 2). The themes were related through a central organising concept of 'Perinatal mental health care as a new frontier for community pharmacy'.

4. Theme 1: *Doing* Mental Health Care

4.1. Initiating difficult conversations

In their current practice, a number of participants referred to new mums coming into the pharmacy who visibly need support or express their feelings to the pharmacist.

> *"I think I have [experience] with mums, new mums who can't cope, crying in the pharmacy"* (F1, Focus Group 3)

> *"Very generally, "I'm feeling down.""* (M1, Focus group 1)

Whilst other participants had not come across this but acknowledged that some individuals may be experiencing mental health issues but are not actively accessing support or visibly expressing their feelings.

> *"I haven't come across a woman that has actually approached me. So, there are people that are going through it silently"* (F3, Focus Group 1)

If a woman appears distressed, being proactive and asking an open question to start a conversation about mental health was discussed. Participants thought this was the best approach to get a woman to talk about how they are feeling.

> *"'Are you okay? Is there anything that I can help you with?' More of an open, general question. And then I think if they say that they're okay, I'll say 'Is everything okay? You've just had a baby.' Because they're with the baby, obviously. 'Is the baby sleeping well at night?' And that's when they start to open up. 'No, the baby never sleeps.' I've actually had a referral on that with a CPCS [Community Pharmacist Consultation Service] with a non-sleeping baby"* (F1, Focus group 3)

Table 2
Themes and subthemes.

Theme	Sub-theme
***Doing* Mental Healthcare**	Initiating Difficult Conversations
	Joined-up thinking and linking-up services
Willing, but Unable	Working against the clock
	Scope for a Pharmacist-led perinatal mental health service?
Introspection and reflection	Knowing What They Don't Know
	A Crisis of Confidence

[2] Here we use the term *'Doing'* in the sociological sense, whereby this speaks to praxis of the professional embodying and enacting a role, as a form of performativity.

Participants spoke about their experiences in initiating conversations and providing advice to women, partners and/or fathers who come into community pharmacies in the postnatal period.

> *"I think the most important thing is to tell them this isn't going to last forever. It's a self-limiting thing. And if you're lacking sleep or can't get the housework done or cook a meal, there's nothing you can do, it will get better. But there's very little that you can do other than refer them to the doctor if you think they've got postnatal depression, and usually the worst cases would be the ones who look as if they've not got dressed this morning, they're literally coming in in their pyjamas"* (F1, Focus Group 3)

An existing relationship with patients, the setting, and whether the patient looked in distress were factors which influenced the participant's decision to initiate a conversation about mental health.

> *"I think if I knew somebody and it was a regular customer, and depending on what the relationship was like before, interaction-wise, then I would be quite confident in talking to them about how they're feeling, after the pregnancy"* (F2, Focus Group 2)

> *"One of the issues I have is we're in a supermarket. So, it's not as private, even though we have a consultation room. It's really crazy and you don't get that opportunity to observe that much. You've got the baby a little bit further away. If I saw someone obviously distressed, yes, I would and if I knew them. Otherwise, I don't think I would have the opportunity to"* (F1, Focus Group 2)

Participants discussed providing reassurance while information is given on 'baby blues' and its self-limiting nature following the birth of a baby. Signposting to other trained healthcare professionals for additional support for potential cases of postnatal depression was also spoken about.

> *"I have had the partner, fathers coming in, in the first couple of weeks after the baby is born, and saying 'my wife or partner is very run down, very tearful and can't sleep very well'. So then you ask how they're coping and I usually say that you do get postnatal, not depression, but the first couple of days after the baby is born you can get what's called the baby blues, but that shouldn't last for too many days and if it goes on and on, obviously they do need to talk to their health visitor or the doctor"* (F2, Focus Group 2)

4.2. Joined-up thinking and linking-up services

When asked about referral, several of the participants were not aware of where to refer women to, if necessary.

> *"No, I also don't know where one would signpost or refer them to so …"* (M1, Focus Group 2)

> *"No, to be honest, I would actually have to look it up online, yes"* (F1, Focus Group 2)

One participant also spoke about finding a local bereavement group for a woman who suffered a perinatal bereavement:

> *"I just found a bereavement group, because there was one of the mums who lost a baby, and that was one of the groups I know of in the area, but I suppose I would have to find out actively"* (F3, Focus Group 2)

Some of the participants spoke about referring women to healthcare professionals including midwives and General Practitioners (GPs; 'family doctor') especially if a woman appears distressed. Limited access to primary care services was also highlighted by the participants as a challenge for women who require further support.

> *"Maybe back to the midwife if they're still seeing them, but we don't have the ability to refer. I might suggest that they go to the doctor or make an appointment or say, 'Would you like me to make you an appointment with*

the doctor?' if they say they can't get one. I'll phone the surgery and ask for an appointment. I'll say 'I've got a very distressed patient here and I think she needs to see a doctor. Can you fit her in?" (F1, Focus Group 3)

"Knowing what's available, yes because personally, like we said, normally we'll just refer them to the GP, but with the GP if they can't get an appointment or at times because right now a lot of people are just [laughs] complaining about their surgery and trying to get appointments with a three or four week wait, and if they're waiting for that long" (F3, Focus Group 1)

Inadequate support for women following the birth of a baby was highlighted by one of the participants, in particular, the lack of access to local services such as health visitor clinics which serve as a place to talk to a health professional. In addition, the importance of home visits for assessing postpartum wellbeing was referred to.

"So I remember when I had my babies, I'm just trying to think of that. And they used to have midwives, there were clinics and the health visitor clinics. Remember you brought your baby, so there was some person those women could talk to. From what I gather, those clinics are there no more, it's just the doctors' surgeries. So where do these women go? And remember those midwives or health visitors used to come home as well to see the baby or whatever. That was very important because obviously, I could put my makeup on and come into the pharmacy and look good, but how am I at home?" (F3, Focus Group 2)

The lack of pathways for community pharmacists to refer women to existing mental health services was spoken about in addition to having no formal pathways to refer to other healthcare professionals such as GPs.

"And I know that with the Midwives, the Nurses, the Doctors and Midwives, what they'll do is if you do express that you're a little bit worried about how you're feeling, if you've been feeling a little bit low, they will send your details onto the Talking Therapies, and Talking Therapies will then get back to you and say "There is this interest. Can we talk a bit further about it?" Pharmacists don't have that connection, so even though we're healthcare professionals …" (F1, Focus Group 1)

"Yes, but at the moment pharmacists aren't allowed to do any referrals. It's not in our remit. We can make a suggestion or pick up the phone and tell the doctor 'I've got a patient here who needs to see you today, please can you do me favour?' But we can't really send them somewhere else, and I don't see how we could have that inbuilt in our service" (F1, Focus Group 3)

While one participant spoke about her own experience of seeking mental health advice in the postnatal period and highlighted the lack of support available and the difficulty accessing information although she was a healthcare professional.

"I personally after my first had postnatal depression and I was like "I just don't feel right, something's not right." I tried to speak to the doctors about it because I didn't know where else to turn to, because where else is there? As a Pharmacist I don't know, and then in my own person I don't know. And the Doctors, they don't want to know, which is difficult as well because they're just like "Well, you just kind of need to get on with it." So then after that, you're just like "Okay, so where do I go?" So if in a healthcare professional capacity you don't know where to go, then how are you supposed to advise to someone else where can they go?" (F1, Focus Group 1)

5. Theme 2: willing, but unable

5.1. Working against the clock

The participants spoke about how their current workload impacts practice, which is not only related to the COVID-19 pandemic, but to the multiple services already delivered by community pharmacists. Providing mental health advice was perceived as challenging due to having limited time to counsel and advise different groups of people including pregnant or postpartum women.

"Unfortunately in any pharmacy at the moment, it's been like this not just because of the pandemic, for quite a few years, the demands on our services are so high that, which patient do you talk to, and spend a lot of time talking to them, counselling them, advising them and there's just too many health issues with too many different people, so to categorise and say okay, I'm proactively going to talk to pregnant women or women who've had a baby. It would be a little bit difficult. I think the constraints of time, it's just ridiculous" (F2, Focus Group 2)

"How many people, and how many patients and how many groups can we actually give effective, productive advice to and dispense and check, and go out, and speak to other customers, and hear their views" (F1, Focus Group 2)

The time required to assess mental health and decide on an appropriate pathway to refer women to was also recognised as challenging.

"… it could be quite time-consuming as well, because if you've got to get down to what's actually wrong and then make a decision as to where you're going to send this person, that could take some time" (F1, Focus Group 3)

The need for other well trained pharmacy staff was also highlighted as essential to support community pharmacists.

"well-trained staff to deal with all these issues as well, because one person can't do everything" (F2, Focus Group 2)

5.2. Scope for pharmacist-led perinatal mental health care

The participants were asked about their views on providing community pharmacist led PMH care. A place for such support in a community pharmacy setting was recognised while also building on the pharmacists' existing knowledge and skills to provide such care highlighted.

"I personally would say yes, and the reason why is because postpartum depression or postpartum anxiety or postpartum OCD [obsessive compulsive disorder], that's all starting to be talked about now" (F1, Focus Group 1)

"I feel that this is something that we can build on. Okay, yes, we're not experts in it [mental health]. What does a pharmacist know about how to diagnose someone who might have mental health issues? But then if we stay with that mentality, they're only going to take it away from us and give it to someone else" (M1, Focus Group 3)

Working with other healthcare professionals such as health visitors was also referred to as being an important component of care.

"I think the children's centres would be a good place because they've got the health visitors, they would be a good team to work with regarding this" (F2, Focus Group 3)

The participants had views on how mental health could be assessed in a community pharmacy setting, and how referral to other healthcare professionals such as GPs could be incorporated into care.

"But what you can do is agree on some red flags and go if a lady who's just given birth in the last three, four months comes to you and she has these red flags, then maybe you can do something a bit like we do there where you have a two-week referral. 'Doctor, this person needs to be seen" (M1, Focus Group 3)

"Could there be some kind of scoring system? I know with mental health like depression there is that scoring system where you score them as to how

they're feeling and there are certain questions about how they're feeling, like depression." (F3, Focus Group 1)

The difficulty in assessing mental health and the lack of referral capacity for pharmacists were highlighted as barriers to implementation of care.

"Well, I think that it's difficult for us to make a decision as to what is actually wrong and who to refer to. So, we need somewhere they can go for an assessment really, but as pharmacists, we can't refer. Where do we refer to? We don't have that ability to write 'You need to see the doctor; here's a referral note" (F1, Focus Group 3)

6. Theme 3: introspection and reflection

6.1. Knowing what they Don't know

Participants spoke about not being experts in mental health and not feeling qualified or in a position to assess mental health and provide counselling.

"I don't think that we're actually qualified to decide what's wrong. We can guess what's wrong and from what they're telling us we can think we know what's wrong, but we won't necessarily be right" (F1, Focus Group 3)

"… they've come for advice, "What can I do? I'm feeling down." But I wasn't in a position; I referred, I said "You should really be speaking to your GP" (M1, Focus Group 1)

The perception that women would not view the community pharmacist as having sufficient knowledge in mental health was spoken about, while the perception that women would only expect the pharmacist to answer superficial questions was also discussed. There was also doubt about whether women would have enough confidence to discuss their mental health with the community pharmacist.

"… I'm not so sure how many women would actually consider the pharmacy as a first port of call. I think they're more likely to feel that we don't have enough knowledge about it. And they might ask us superficial questions, but I don't think they would expect a lot from us somehow, that's how I would feel. Although they would see us and we're more approachable because they can just come to us without an appointment, I'm not so sure if they would have enough confidence into going deeper into their problems with the pharmacist" (F2, Focus Group 2)

6.2. A crisis of confidence

When asked about how confident they felt in providing mental health advice, all the participants rated themselves as not feeling confident. Most pharmacists rated themselves below 5 on a scale from 1 to 10. Lack of confidence was related to lack of training and lack of knowledge.

"I don't feel confident in providing advice, I just don't feel I have enough knowledge or training to do it." (F2, Focus Group 3)

"Once they open up then maybe you can talk – obviously in a private consultation room or somewhere it's more private – once they open up, but it's the start, "How shall I approach this subject?" that's where obviously I would lack confidence" (M1, Focus Group 1)

Lack of knowledge on an appropriate care pathway and lack of ability to monitor women was referred to by one participant.

"I think it's probably lack of knowledge really. What would be the steps if someone did come? We do the general counselling, but how would you monitor this person, my concern would be" (F1, Focus Group 2)

Only one participant reported having prior training in mental health which was related to mental health and suicide. Having a structured assessment and appropriate pathways were viewed as strategies to increase confidence.

"We have done mental health and suicide training and they've always told us not to be scared to bring up those words and to find out, because you could be saving that one person, right?..I would feel confident in terms of being able to approach a woman if there is some kind of pathway or programme or something where we can have a sit down and actually go through those questions, find out a score, see what we can do, and also knowing where to refer. Even if there was Talking Therapy" (F3, Focus Group 1)

7. Discussion

In this study we explored community pharmacists' attitudes, counselling practices, and barriers to providing mental health advice to perinatal women. Thematic analysis of focus group data identified three themes, related through a central organising concept of 'Perinatal mental health care as a new frontier for community pharmacy'. Our findings demonstrate that community pharmacists often provide mental health advice and support to women and their partners in the postnatal period. All participating pharmacists reported a lack of confidence in providing mental health advice, which they associated with inadequate knowledge and training opportunities. Several organisational barriers were identified including a lack of a formal referral pathway to existing mental health services and other healthcare professionals. Our work highlights the unique position of community pharmacists which could be leveraged for identification of PMH problems. Furthermore, our study identifies key strategic areas which could be focused upon to develop community pharmacists' skills and competencies in order to deliver fit-for-purpose PMH care in a community setting.

Community pharmacies are highly accessible and do not have an appointment-based system, which provides opportunities for women and their partners to consult the community pharmacist in the perinatal period, which was evident in this study. As a result, community pharmacists are ideally placed to be a first point of contact to initiate a conversation on mental health and provide a link between other healthcare professionals, such as GPs, midwives or health visitors as highlighted in this research. In this study, we identify several organisational barriers which limit the ability of community pharmacists to play this triage-type role. The lack of a formal referral process was highlighted by the participants of this study. Currently the system relies on community pharmacists asking new mothers to self-refer to their GP if their mental health is deteriorating. Other healthcare professionals can refer to community pharmacists, for example, for minor illnesses through the Community Pharmacist Consultation Service.[22] However, community pharmacists cannot formally refer to other services which could result in women not accessing appropriate mental healthcare. This is consistent with a previous study reporting a lack of established referral systems as a barrier to PMH service provision in Australian community pharmacists.[18] Furthermore, there was a lack of clarity about directing women to appropriate mental healthcare avenues. Referral to existing community care specialist services for PMH problems were not highlighted by any pharmacist, suggesting greater awareness is needed. Thus, changes such as the establishment of a referral process and improvement in pharmacists' knowledge of existing mental health services could have a positive impact on PMH care.

There is increasing emphasis on community pharmacists to provide more patient centred services such as smoking cessation, alcohol reduction and weight management interventions in addition to medication-related activities.[23] This includes a role for community pharmacists in engaging in screening and risk assessments, provision of medication reviews and adherence interventions for patients with mental illness.[15] In this study, community pharmacists demonstrated a willingness to provide mental health support for perinatal women,

which is in line with previous research indicating that pharmacists are willing to incorporate perinatal depression screening into their practice.[18] The participants suggested screening for risk of depression, along with appropriate referral pathways. Community pharmacists commonly provide screening for physical health conditions such as hypertension or diabetes,[24] and are in a unique position due to their accessibility to engage in screening for mental health problems. Screening tools for risk of perinatal depression are widely utilised in primary care settings in the UK,[25] which could be introduced in a community pharmacy setting. Several studies have demonstrated feasibility of community pharmacists to perform depression screening and referral to appropriate healthcare services.[26–28] Further research is needed to assess whether training community pharmacists to identify PMH problems such as postnatal depression to then refer to other trained professionals is feasible, and effective. As time pressures on community pharmacists were highlighted in this study, which is well documented as a practice barrier,[29–31] adequate resources, and support would need to be addressed before feasibility of such care could be explored.

Community pharmacists reported a lack of confidence, feeling un(der)qualified and a lack of expertise in providing mental health advice. This was particularly evident around initiating a conversation related to mental health. A lack of confidence is consistent with previous research showing community pharmacists are more comfortable providing physical health services than mental health.[32] The lack of confidence was linked to pharmacists reporting not feeling adequately trained to enable them to provide mental health advice. Inadequate training has been recognised as a barrier to implementing mental health support in community pharmacy settings.[29] One training programme, Mental Health First Aid (MHFA), is recognised internationally and teaches participants to identify and respond to signs of mental illness. In the UK, MHFA training should be considered for all practising community pharmacists and student pharmacists as part of university curricula similar to pharmacy programmes in other countries.[33] This would ensure community pharmacists have parity of esteem when it comes to mental health and can provide appropriate advice to perinatal women in addition to the wider community. Additionally, in the UK, community pharmacists have access to the Centre for Pharmacy Postgraduate Education (CPPE) amongst other resources where there are resources and training related to mental health.[34] The findings of this study suggest more awareness around national mental health and wellbeing resources and training opportunities are needed.

7.1. Strengths and limitations

This study adds to the limited knowledge base exploring community pharmacists' attitudes and experiences in providing mental health advice to perinatal women. The study used a qualitative research design to explore views of community pharmacists, providing richness of data. The study had a few limitations. The participants included community pharmacists who were interested in the topic, which may have led to bias. They also worked in high-density urban settings; with high levels of ethnic minority populations, wide-ranging socio-economic statuses, and varying amount of social complexity. It is therefore likely their experiences differ from those in more rural areas; both in terms of target populations, and existing service provision, which may influence the findings of the study. Therefore, this may limit the generalisability of our findings. Another limitation was the relatively small sample size of eleven pharmacists which may have not represented a sufficiently broad range of views, although the data was rich enough to saturate around the themes presented above. Finally, there was a higher proportion of female pharmacists (73%) who took part in the study which was marginally more than the current ratio in the workforce where 62% are female.[35]

7.2. Practice implications

Community pharmacists would benefit from additional awareness of national training opportunities to increase knowledge and confidence to initiate conversations about mental health and provide appropriate advice, signposting, and support to perinatal women. Given the current expansion in community PMH services, greater awareness is needed at a local level to ensure community pharmacists are aware of such services to which they can refer women for further mental health support. Introducing a formal referral pathway for community pharmacists to refer women to existing services or to other trained healthcare professionals would also be beneficial.

8. Conclusion

This study highlights the potential role that community pharmacists could play in identifying PMH problems and providing appropriate advice and support. However, lack of knowledge and training were associated with community pharmacists' lack of confidence and competency in providing mental health advice. Lack of a formal referral pathway to other healthcare professionals and existing services, e.g. GP, midwife, and health visitor were also identified as organisational challenges that prevent pharmacists from providing adequate mental health support. Further research is required to demonstrate the feasibility and effectiveness of community pharmacist led PMH care embedded into community care. MHFA training should be considered for all practicing community pharmacists in the UK to ensure they are confident to provide mental health advice to perinatal women and the wider community. In addition, greater awareness is needed of national resources and training opportunities on mental health for community pharmacists.

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Author statement

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Declaration of competing interest

The authors declare no competing interests.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.sapharm.2022.10.005.

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