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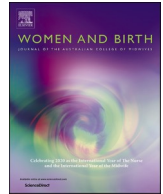
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Creating coherent perinatal care journeys: An ethnographic study of the role of continuity of care for Danish parents in a vulnerable position

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ABSTRACT

Background: While continuity of care is a core element of high-quality maternity care, it is potentially even more important for pregnant women and their partners who are at risk of adverse health outcomes because of psychosocial vulnerability. However, little is known about how a coherent care journey can be ensured for women and families who may require interdisciplinary and inter-sectoral services during pregnancy and the postnatal period.

Aim: To explore the role of continuity of care in creating a coherent care journey for vulnerable parents during pregnancy and the postnatal period.

Methods: An ethnographic study conducted in Denmark based on interviews with, and field observations, of 26 mothers and 13 fathers receiving services due to mental health problems, young age, past substance abuse and/or adverse childhood experiences.

Findings: Three key findings emerged: 1). Developing relationships allowed parents to know and feel known by care providers, which helped them feel secure and reach out for support. 2). Handover of information allowed parents to feel secure as their need for support was recognised by care providers; some parents, however, felt exposed when information was shared 3). Receiving relevant services allowed parents to have their needs for support addressed, which requires easy referral pathways and coordination of services.

Conclusion: All forms of continuity of care should be prioritised in the organisation of maternity care services for women and families in vulnerable positions. While relational continuity is important, continuity of care must also reach across providers, sectors and services to ensure coherent care journeys.

Statement of significance

Problem or Issue

Psychosocial challenges make pregnant women, their partners and infants vulnerable to adverse health outcome.

What is already known?

Continuity of care is a core element of high-quality maternity care and is potentially even more important for vulnerable, pregnant women and their partners, many of whom receive interdisciplinary and inter-sectoral services during pregnancy and the postnatal period.

What this paper adds?

Relational continuity is identified as important, but continuity of care must reach across providers, health sectors, and services to ensure coherent journeys for vulnerable parents.

1. Introduction

Due to complex and interrelated social and/or psychological challenges, pregnant women in a vulnerable position are at risk of adverse health outcomes during pregnancy and the postnatal period [1–5]. Reflecting international recommendations [6,7], multidisciplinary and inter-sectoral services beyond the standard care program are offered by the Danish health services when the woman and/or her partner are exposed to, or have a history of, mental illness, limited social support, adverse childhood experiences, drug and alcohol misuse, poverty, young

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age, and trauma and violence [8]. This includes intensified contact with the main healthcare providers in the Danish antenatal care program, including midwives, health visitors, general practitioners and obstetricians, and, in some cases also care from psychologists, psychiatrists and social workers [8]. Due to the need for multidisciplinary and inter-sectoral services delivered by a diverse range of healthcare providers, care must be coordinated to ensure that women/couples with complex needs are offered coherent and integrated care journeys [8]. Continuity of care has been identified as central in providing high-quality care for vulnerable pregnant women, and it is recommended that support include regular contact with health professionals with whom they are familiar, antenatal home visits by a nurse or midwife and the assignment of a care coordinator [9].

Continuity of care has been defined as “the degree to which a series of discrete healthcare events is experienced by people as coherent and interconnected over time and consistent with their health needs and preferences” [10]. Highlighting it as a key feature of high-quality maternity care, the World Health Organization states that continuity is capable of avoiding fragmentation and poorly coordinated care [10,11]. To ensure continuity of care, the service user must be the focal point from which care episodes delivered by a diversity of services and providers are experienced as coherent and integrated [12]. Several types of continuity of care have been identified, including *relational continuity*, which involves establishing a therapeutic and trusting relationship with one or a group of familiar healthcare providers over time [12]. Continuity also involves *informational continuity*, in which coherence between services and providers is achieved through the transfer of information about individual preferences and values [12]. The third type of continuity is *management continuity*, which refers to the provision of separate healthcare services in a complementary, flexible and timely manner that is responsive to the individual’s changing needs [12]. It has been proposed that the experience of continuity of care is highly contingent on individual and social contextual factors [13], which calls for the empirical investigation of all aspects of continuity of care as experienced by service users in a particular healthcare setting.

A Cochrane Review has demonstrated positive birth outcomes, including a reduction in the number of preterm births, when women with a low level of health risk receive pregnancy and birth care from one midwife or a small team of midwives [14]. In the case of vulnerable women, observational studies have found a positive association between continuity of midwifery care and improved perinatal outcomes [15–17]. However, a recent study did not establish any significant effects of a model of continuity of midwifery care that was implemented to reduce preterm births in a disadvantaged community. This indicates the need to understand the contextual mechanisms that contribute to relational continuity for vulnerable women [18]. Likewise, there is evidence of the benefits of sustained nurse home visits when a relationship is established between the family and their child and family health nurse over a two year period [19]. Midwives have, moreover, reported that in work with vulnerable women, developing rapport enables them to help the women navigate a complex health system, attend to their needs in a timely manner and make them less reluctant to engage with services [20]. Other studies exploring women’s experiences with maternity care services have found that relational continuity can help vulnerable women feel secure and supported, as familiarity with the professionals contributes to increased trust [21–24].

However, the role of continuity of care for parents in a vulnerable position is poorly researched. Previous studies have primarily highlighted the role of relational continuity, whereas the maternity care

received by vulnerable parents tends to span across a diversity of services, providers, and sectors, as well as different locations and times. Further research is thus needed to assess the importance of other forms of continuity. In this paper, we explore the role of continuity of care in creating a coherent care journey for parents in a vulnerable position during pregnancy and the first 12 months following birth.

2. Methods

2.1. Research design

This paper reports findings from a larger ethnographic field study conducted in Denmark, which explored the experiences of vulnerable parents who received multidisciplinary and inter-sectoral services during pregnancy and the postnatal period. By using participant observation and informal and semi-structured interviewing, ethnography can generate knowledge of human experiences and practices while considering the social and cultural context [25,26]. The study was informed by an interpretive philosophy of science in which the researcher’s engagement with the field of study is essential to the collection of data. Based on the same empirical dataset, we have previously reported on parents’ fear [27], and their perspectives on supportive parent–professional encounters [28].

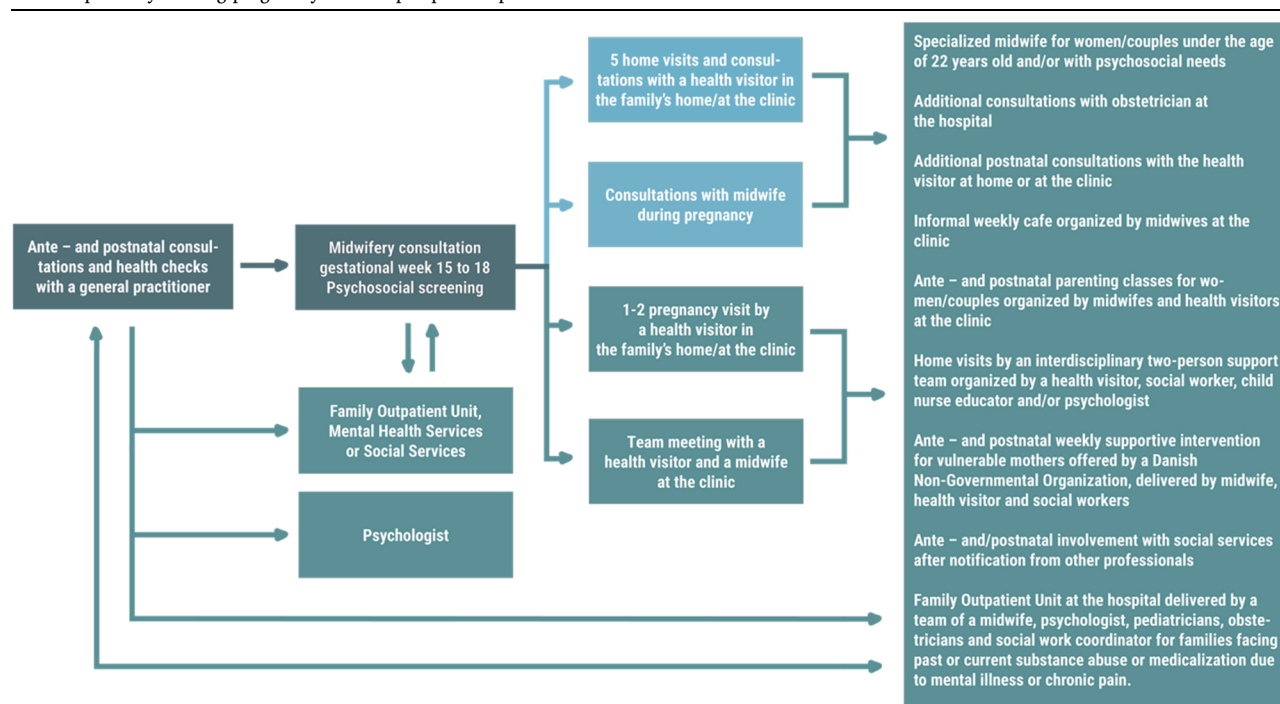
2.2. Ethical considerations

The research project was carried out in accordance with Danish legislation [29], and the Declaration of Helsinki [30]. In Denmark, qualitative research is solely based on participant informed consent and cannot be submitted for ethical approval by a scientific committee [29]. The parents’ informed consent was collected after they had been informed of the research project verbally and in writing. To ensure confidentiality and anonymity, data were handled to ensure the integrity of participant. Pseudonyms were used in the analysis. The study is listed with the Danish Data Protection Agency (Record No. 2019-899/10-0020).

2.3. Setting

The fieldwork took place from April 2018 to September 2019 in Aalborg Municipality in the North Denmark Region. In Denmark, access to health services, including maternity care, is free and equal. Four different levels of maternity care are offered, depending on individual needs [8]. In the North Denmark Region, screening for psychosocial vulnerability is routinely undertaken during the first midwifery consultation to identify pregnant women who may benefit from additional services. Women or couples with complex social, psychological and/or medical needs that may require multidisciplinary and inter-sectoral services (Levels 3 and 4) are identified as being in a vulnerable position. The basic level of maternity care services (Level 1) involves three antenatal consultations with a general practitioner and four to seven consultations with a midwife. First-time parents are offered group-based parenting education during pregnancy and the child’s first 12 months, provided jointly by midwives and health visitors. Five postnatal home visits or consultations with a child health nurse/health visitor are routinely offered. While relational continuity across pregnancy, birth and the postpartum period is not guaranteed, the woman often sees the same midwife during pregnancy and the same health visitor postpartum. Besides these universal Level 1 services, additional

Table 1
Referral pathways during pregnancy and the postpartum period.



services and support is offered when vulnerability is identified. Women with the most complex needs may be assigned a specialised midwife. While continuity of midwifery care during pregnancy is ensured for this group, this same does not apply to birth or the postpartum period. Parents can choose between a parenting class tailored to parents in a vulnerable position or the standard class. During pregnancy, the women and their partners are also offered one or two visits by a health visitor and more frequent visits post-partum. Additionally, a wide range of regional and municipal public health services as well as non-governmental organisation services may be offered. Mental health services are only accessible via the family's general practitioner. Pregnant women/couples who are initially allocated level 1/standard care can be allocated a higher level of services by their midwife, health visitor or general practitioner if the need arises over time. Care levels are thus flexible. Table 1 illustrates the referral pathways during pregnancy and the postpartum period, including an overview of the specialised services available.

2.4. Recruitment

A purposeful recruitment strategy was used [31]. For inclusion the woman/couple had to 1). Expect a child or have recently given birth, 2). Reside in the municipality under study, 3). Speak Danish, and 4). Receive Level 3 services in pregnancy and/or postpartum due to one or more vulnerability factors (boundaries to Levels 2 and 4 were flexible). Maximum variation was sought to achieve diversity [31], in terms of vulnerability, parity, age and socioeconomic position. Based on the principles of information power and taking into account the relatively broad study aim and our wish to achieve variation [32], we planned to recruit at least 25 women/couples. As recruitment was challenging, multiple methods were employed. Potential participants heard about the study from their health visitors and midwives. If interested and agreed, they were then contacted by the first author via text message or the phone. To further aid in recruitment, midwives and health visitors invited the first author to participate in parenting classes and, if allowed by the parents, also in home visits and consultations. This approach proved the most successful as it enabled the participants to meet the first

Table 2
Profile of participants.

	Female (n = 26)	Male (n = 13)
Marital status		
No partner	6	0
Partner/married	20	13
Parity		
Primipara	15	10
Multipara	11	3
Age group		
17–25	7	3
26–33	14	5
34–41	5	5
Occupation		
Student	7	3
Regular employment	7	8
Unemployed	12	2

author face-to-face and ask question about the research. Inviting participants via social media and posters placed in health clinics elicited limited response.

2.5. Participants

Twenty-six women were recruited. Six women were single mothers with no or limited contact with the father. The partners of the remaining 20 women were also invited to participate, 13 of whom accepted, all of them male. As illustrated in Table 2, marital status, parity, age and occupation varied. Most of the women/couples had vulnerability issues related to past or current mental health problems or disorders, including depression, anxiety, ADHD, personality disorder and bipolar disorder. Others were included because of young age, a history of substance abuse, adverse childhood experiences and/or traumatic experiences, including violence and sexual abuse. While the majority received Level 3 services, a few received Level 4 services. Overall, the participants' care pathways differed, with none receiving all the services but only a selection of those listed in the model above.

2.6. Data collection

To gain an understanding of the study field, the first author initially observed midwife and health visitor consultations, antenatal classes, and other services. When a woman/couple was recruited for the study, the first author was generally granted permission to attend their service encounters, including midwifery consultations and appointments with the health visitor in the home or the clinic. Fifty-one encounters were observed with 21 of the participating women/couples, including informal conversations before, during and after the visits. Field notes were jotted down and subsequently developed into substantive field notes. A further 50 interviews were conducted during the antenatal and/or postnatal period. Ethnographic interviews are typically conversational [25], and although a thematic interview guide was prepared, the course of the interviews was adjusted according to the situation to allow for an explorative interview style. The field visits became a shared point of reference in the interviews and enabled the first author to ask questions attuned to the parents' current situation. The time and place of the interviews were chosen by the parents, mostly taking place in their own home. Both individual and dyadic interviews were conducted, depending on the parents' preference. Almost all the fathers preferred to participate in dyadic interviews, while the mothers participated in both interview types. Two or three interviews were conducted with 16 mothers; 10 mothers were interviewed once only. All fathers were interviewed once except one who participated in three interviews.

2.7. Data analysis

The research was an iterative process based on a continuous dialogue involving the research questions, the empirical material, data analysis, theory and writing [33]. Data were entered into NVivo 12 qualitative data analysis software. Each woman/couple was assigned a case identifier for the management of interview transcripts and field notes. Once data collection was finalised, a thematic analysis inspired by Braun and Clarke [34] was conducted. The first author read the empirical material to familiarise herself with the overall care experience of each woman/couple. Data-driven codes were assigned, and preliminary themes were formulated. As the analysis progressed, comparison of the cases helped identify similarities and differences. Codes were continuously regrouped to formulate major themes. Instead of presenting all major themes, the researcher may choose to select a few for in-depth analysis [34]. The overall theme of continuity of care was selected to be presented in this paper. All quotations were translated by the first author and the translation checked in the language revision process.

2.8. Reflexivity

The ethnographic research was conducted by the first author, an experienced fieldworker with a master's degree in anthropology. The second and third authors are senior researchers in the field of maternity care services and certified midwives. The first author's background in anthropology rather than healthcare facilitated access to the field, both in terms of navigating an interdisciplinary field and establishing relationships with the parents. In the encounters with the participants, the researcher explained that her focus was on hearing the parents' perspectives to learn from their stories and experiences.

2.9. Trustworthiness

Several steps were undertaken to enhance the trustworthiness of the study. The iterative analytical process allowed for an ongoing dialogue between our findings and existing research and theory, which served to check the soundness of our interpretations. The development and refinement of themes were continuously discussed within the research team. To demonstrate how the themes and knowledge claims are deeply rooted in the empirical data, interview extracts and field notes have

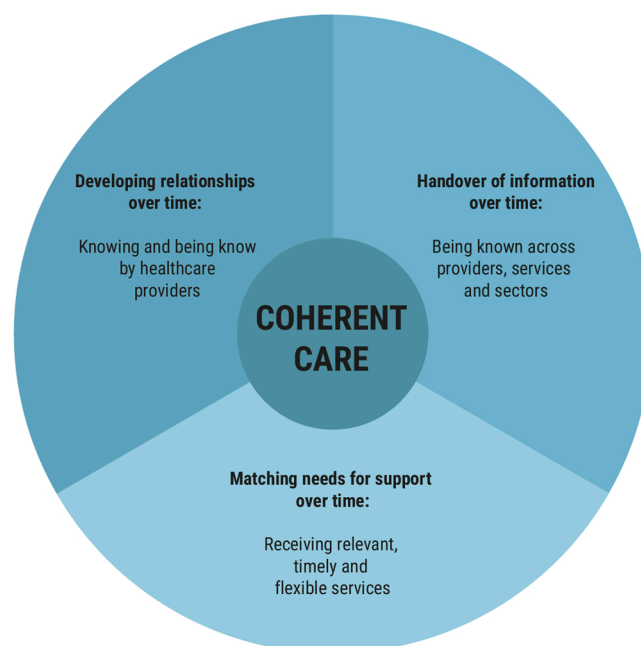


Fig. 1. Coherent care.

been extensively used. Also, contextual knowledge on the Danish setting has been presented as well as a thorough description of the collection of data. This allows the reader to judge the credibility and transferability of the findings.

3. Findings

Three major themes were constructed, as illustrated in Fig. 1. The first theme captured the importance of relational continuity as this allowed for the development of relationships over time. Parents valued knowing and being known by the professional throughout the pregnancy and the postnatal period. The second theme explicated the significance of the parents being known across providers, sectors, and services to illustrate the ways that transfer of information can contribute to coherence as they move in and out of services. The third theme illustrated the importance of receiving timely, flexible and relevant services that were responsive to parents' changing needs, which underlined the necessity of easy referral pathways and coordination of services.

4. Developing relationships over time: knowing and being known by healthcare providers

The parents appreciated being able to develop a relationship with the professionals involved in their care during pregnancy and after the birth. This allowed the parents to gain familiarity with the professional and feel comfortable with them. Esther described the importance of seeing the same midwife throughout her pregnancy:

She was somebody you felt safe being around and we got to know each other a bit. We also talked a bit about personal stuff, which was nice. She kind of gave something of herself in return for me giving a bit of myself. (Esther, postnatal interview)

The importance of knowing the health visitor was also emphasised. Almost all parents received a visit from their health visitor to help establish a relationship prior to birth. For Annette, who was struggling with mental illness, getting to know her health visitor helped her regain control:

Well, we were totally up for that [meeting the health visitor during pregnancy]. Again, I need to feel in control—I need to know who will

be coming into my home [...] It's also because I don't know what kind of situation I'll be in when the baby has arrived—I want her [health visitor] to see what I'm like without [the baby]. (Annette, antenatal interview)

The development of a relationship generally gave the parents a sense of predictability and stability, which helped them avoid the feeling that they were constantly being assessed or evaluated by professionals. This was particularly important for Mia who stated:

I'd just prefer having the same one and not having too many people assessing me. Then she [health visitor] would form her own impression of me, you know ... and what if that impression was not positive, you know. I'm kind of like that ... you form an impression of a person within minutes of meeting them, right? And then I worried that she wouldn't like me, and something would happen. (Mia, postnatal interview)

The parents also trusted that a good relationship would enable the healthcare providers to identify changes in their mood or behaviour, recognise any setbacks, and thus be better prepared to offer support based on this knowledge. Irene, who had suffered from mental illness, explained why she found it important to know her health visitor:

I think we've met twice now, and she has seen my body language and how I'm feeling. When she will be coming here [after the birth] [...] she'll be able to spot if something is wrong, even if I can't see it myself [...] she'll kind of know what I am like. (Irene, antenatal interview)

Similarly, Karina accepted a pregnancy visit hoping that this would enable her health visitor to see if she became unwell after the birth. Although Karina found it difficult to reach out for support, she did call her assigned health visitor when her mental health later deteriorated:

Well ... it's because she says that I can always call if I need to. And then I do call. That's typical [for me] to say to her that I'm not feeling that well—with a quiver in my voice. And to say, "I don't feel very well" [when in fact] I'm utterly destroyed [...] and she could also tell from my voice that I was really upset. (Karina, postnatal interview)

It appeared that knowing the professionals over time facilitated parents in reaching out for support, asking for advice and being honest about the challenges or problems they were facing. Moreover, continuity allowed for more individualised care as the parents felt that professionals knew them well and were familiar with their background, what they worried about, their preferences, communicative styles and needs for support. This was also observed during field visits, when both midwives and health visitors would often refer to past conversations with the woman/couple, as illustrated by the following field note:

The health visitor is sitting on the floor with the baby. She asks the mother whether she remembers how much she had been worrying if the baby was getting enough contact and whether the contact would be good: "Look at him, his contact is so good. He knows you're there, but he is still OK". (Field note, postnatal consultation)

Organisational factors, changes in staffing and maternity leave and sick leave inevitably led to discontinuity. None of the participants experienced relational continuity during birth and the first postnatal days. Often, they had not met the midwife who cared for them in labour in advance and most also experienced shifts during labour and birth. Sarah described:

I thought it was because they had read in my record that I wanted [name of midwife]. And then she walks in, and I'm just feeling secure. I was terrible worried about everything [...]. [She provided] something familiar in all of this thing that made me feel so insecure [...]. But then it became clear that she was assigned to another

woman in labour and that she was just passing by on the way to see her. (Sarah, postnatal interview)

As mentioned above, Irene appreciated getting to know her health visitor during pregnancy. She described her feelings when assigned a new health visitor after the birth:

I actually found it a bit hard. It's also because she had been there when I was pregnant and she ... she knows my story. She knows about all those little things. So I thought it was tough. And I do feel sometimes that I miss that [...] KNOWING that she knows the story. So in that regard I found it difficult that it wasn't her [the familiar health visitor] after all. (Irene, postnatal interview)

Discontinuity can thus be detrimental to parents' sense of security during encounters with professionals, making old worries resurface. However, this could be overcome as described in this fieldnote about a mother with a mental health condition:

The mother says that she felt insecure because it was not her usual health visitor coming to see her, and meeting new people always makes her feel unsafe as she doesn't know what people will think of her. She needs to feel understood and not seen as "crazy". However, the visit went very well as the new health visitor gained her trust, the mother says, in the way she was responsive and understanding of the family's situation. This made the mother feel secure to talk openly about her challenges as the conversation gave her a sense that the health visitor understood her. (Field note, postnatal home visit)

A non-judgemental and supportive approach thus allowed parents to feel secure although they were not familiar with the professional. For a few parents, continuity did not lead to a trusting relationship due to differences in communication styles or the lack of chemistry. The professional's approach is thus of key importance as continuity in itself is not always sufficient to establish a trusting relationship.

5. Handover of information over time: being known across providers, services and sectors

During pregnancy and the postnatal period, parents would move in and out of the inter-sectoral services and have contact with multiple carers. Transfer of information enabled parents to experience a degree of coherence in their journey, which was particularly significant while they were in transition between services or when multiple providers were involved and needed to collaborate on their care. Caroline, for example, appreciated that her midwife received information from the mental health service:

[I]f I had to start explaining these things [her diagnosis], then people might think, "It can't be that hard, why don't you just pull up your socks?" It makes it easier for me to be open when I kind of feel that people already know about it. It has really helped me a lot that there's been one professional who wrote something about me—so it is not just me making things up. (Caroline, antenatal interview)

With information being transferred, the parents did not have to repeat their stories during encounters with professionals or when they were referred to a new service. Emily, who had previously experienced a traumatic birth, disclosed to her midwife that she felt scared about being discharged early from hospital after the birth:

I didn't feel safe about it. Because of the baggage I'm carrying. That we're both carrying. So, I mentioned it already there, actually the very first time, and she [the midwife] made a note about it in my medical record for the hospital. (Emily, postnatal interview)

This illustrates that the known professionals played a key role in ensuring that information was transferred, which allowed for individualised care as the family's challenges, their wishes regarding care and

need for support were known across services and providers. Similarly, Amalie had worried that her medical history would be overlooked when she went into labour:

I worried that I would be talking to [...] somebody who wouldn't find a bit of nausea and dizziness and stuff like that to be all that important. That I would just have to stay home [during the early phase of labour]. And then I'd just lie here at home and die without anybody knowing. It just freaked me out. But it was SO nice to have it so clearly noted in my medical record [...]. Having a plan was really great. (Amalie, postnatal interview)

In contrast, when information was not transferred or not acted on by professionals, this created a feeling of insecurity in the transition between services. Laura, who developed mental health problems following birth, said:

I discussed a lot of things with my midwife at the antenatal clinic—things like my birth plan, but not a single thing was used when I went into labour. I think that's a bit weird—nobody knew anything about me. And nobody knew about [my fear] of losing [the baby]. Nobody said, "We've read your medical record, and we can see you're a bit worried. Everything will be OK." It wasn't like that. I actually felt like I had to tell it all over again [...]. I felt that in between the contractions I had to give them my medical history. That was also when I began to feel really insecure—I started shaking, and things like that, because I really didn't feel they had everything under control. They did [...], but I just had a feeling that I needed to remember to tell them this, that or the other, because if I didn't, then (Laura, postnatal interview)

When parents had to retell their entire life story or their support needs, this was generally experienced as exhausting as explained by Natalie. She felt that her health visitor was just another professional to whom she needed to tell everything: "When you meet somebody, you have to tell them about your [mental health] diagnosis and the whole story. I'm just so used to it, it's just like this ... [makes a repetitive sound]." (Natalie, antenatal interview). Additionally, when Emma, a young mother, was assigned a new health visitor and social worker, her old fear of being judged resurfaced. She hoped that the transfer of knowledge from her current health visitor, whom she trusted, would ease the transition:

I worry that they'll be thinking ... oh, she's so young, this one. But then I do hope that they will take a proper look at my care journey to see what I have been through—what the health visitor wrote, so it's not like they've just skimmed it over quickly. I just don't like that. [...] Because [name of health visitor] she WAS here when it happened. So I find it a bit anxiety-provoking. (Emma, postnatal interview)

However, some parents' uncertainty about how information would be used made them apprehensive about the sharing among professionals. For example, Carla was ambivalent about having her social worker access her medical record from an admission to psychiatric treatment:

But I also told her [the social worker], "If you are going to get the files, it would make me sad [...], but if that is what you think is needed to get a fuller picture, you can do it. But I just don't want you to focus only on that." [Interviewer asks why] Because when I was committed to the psychiatric system, I was really, really ill. (Carla, antenatal interview)

Handover of information could thus be experienced as risky. Noah, who had negative experiences with professionals, worried about what his health visitor would write in his medical record after the first home visit:

As a person, she was really nice. Kind and pleasant—and she seemed to be very understanding. But I think I'll always have doubts about those professionals. Whether they just act like that when they are here—and then it's a totally different picture I get in contrast to what they are writing in the records [...] and what they're passing on. I don't trust them that much, but I'm trying to be open about it. But being trustful, that's difficult. (Noah, antenatal interview)

While it can contribute to ensuring coherent care by bridging different services, providers and sectors, the handover of information in medical records or between professionals can also leave parents feeling vulnerable and exposed.

6. Matching needs for support over time: receiving relevant, timely and flexible services

Throughout pregnancy and the postnatal period, parents were referred to and received diverse services. During field visits it was observed that midwives and health visitors typically played a key role in informing and linking parents to available services in the community. For example, it was Emily's midwife and health visitor who referred her to relevant services:

You might say that with everything that happened afterwards [the first midwifery consultation]—what if the midwife I saw had neglected it? [...] It was like a cascade [effect], like rings in the water, kind of. So, if our midwife hadn't spotted it and acted on it and contacted our health visitor, and our health visitor hadn't thought, "OK, we need to do something about this." So really, all the way through, it has really been massively person-dependent—a bit scary, really. (Emily, postnatal interview)

Coherent care journeys were contingent on the professionals' referral of parents to services that were aligned with and tailored to their situation. For example, being referred to a long-term group intervention was experienced as highly meaningful to Christina as this addressed her particular need for support:

[It has given me] security in a very insecure period [...] I mean, just this thing about hearing how I can be the best mum possible, right? That has given me the mental ballast that I may not have from my own home, to make me able to give [my children] a good, secure upbringing. (Christina, postnatal interview)

Gaps or discrepancies between what the family needed and what professionals referred them to, left some feeling unsupported. For example, Amalie felt disappointed after her first visit from the health visitor:

I don't really know what I had expected, but I don't think it was much help [...]. I think that I may have counted on her [the health visitor], that we would sit down and draw up a plan, and she would say, "OK, if you have these feelings today, then this or that is what you should do [...]." I'm aware she doesn't have those [therapeutic] qualifications, but still, I thought it would be like that, instead of her telling me about available services, because we might as well have discussed that over the phone. (Amalie, antenatal interview)

Hoping to be assigned to a psychologist, Amalie accepted further referral to an interdisciplinary team in her municipality; however, this never happened, and her mental health problems were ultimately left unaddressed. Consequently, care journeys can be experienced as fragmented even though a continuous parent-provider relationship is in place.

Furthermore, it was also important that the services that the parents did engage with were flexible and easily accessible. Knowing that she could always contact her midwife gave Esther a sense of having a safety net, if her mental health should worsen:

There were scheduled visits but apart from that, it depended on what I needed. If I was going through a period feeling I needed a little extra [visits], we would do that. But really, there wasn't that much of a need for it, but it was nice to know the offer was there. (Esther, postnatal interview)

When the care system was flexible and adaptable, care could be attuned to the parents' situation as it developed over time. It was Britt's experience that her health visitor continuously adjusted her care, paid her additional visits and made phone calls in between visits, which made her feel well supported: "I don't feel let down in any way. I feel like people are there for me completely. You know, I'm given what I ask for [...] I feel that they have my back." (Britt, postnatal interview).

In contrast, when parents experienced long waiting lists or limited contact with professionals, they became frustrated. For example, when Sarah needed support for breastfeeding, she was unable to establish contact with her health visitor and the interdisciplinary support team could not offer immediate support:

Actually, I was quite upset that they couldn't really help me. I had counted on that. Because at one point, when everything got out of control, I just couldn't cope anymore, and she [the baby] was just screaming, and [the boyfriend] couldn't cope anymore, and we didn't know what to do. Everything just crashed. I called them the next morning to say that I needed help. I didn't know what kind of help I needed, but I did need help. And that's where I need to call you. And they were like, "Well, but how can we help?" "Well, I just need help, I can't stand it, we've got all these problems." But they were not an acute team. They couldn't offer acute help, but they could book me for a consultation in two weeks' time ... (Sarah, postnatal interview)

Care needs fluctuated over time, with some parents needing less support, some more, or a different type of support depending on often unforeseen challenges faced along the way. For Peter, the first months postpartum had been very difficult due to his wife's mental health, and he would have preferred earlier and more frequent contact with the interdisciplinary support team, explaining: "No, it was not difficult to get in contact with them. But from the time you spoke to them about visiting, it would be five weeks [until the appointment], and then they came once a month." (Peter, postnatal interview). The majority of parents became very stressed when new challenges arose, particularly when coupled with existing challenges and the task of caring for a new-born baby. Laura, who developed mental health problems following the birth, suddenly required admission to a psychiatric ward but was discharged without referral to any additional mental health service:

So, that week when I came home [from the psychiatric ward], I just felt ... really bad, I'd say. I felt like there was no help available. Because we had just been told to contact our general practitioner [for referral], and I just know that if I contact a general practitioner, six months will pass before I can see a psychologist. I can't wait six months. This is the state I'm in. (Laura, postnatal interview)

In general, parents relied on referral to publicly funded psychologists, with their long waiting lists, unless they had the means to pay for therapy themselves. In such situations, when a need for support was not addressed, the parents found there was no safety net when they reached out for help. To ensure coherent care it is therefore paramount that parents receive timely, flexible and relevant services that match their current needs for support.

7. Discussion

This article has explored the role of continuity of care in creating coherent journeys for vulnerable parents during pregnancy and the first year following birth. Our findings have demonstrated that all forms of continuity of care (relational, informational, management) were

essential to the parents' experience as their support needs stretched across providers, sectors and services. Relational continuity was central for parent' perception of care coherence, as this made them feel secure and well supported in engaging with services. Secondly, transfer of information as parents moved in and out of services ensured that they did not need to repeat their story over and over and allowed for their individual situation to be known across sectors and services. On the other hand, the sharing of information can be a fraught issue if parent worry about being judged or are concerned about potential negative consequences. The timeliness of services is also significant, as receiving relevant services that matched parents' perceived need for support were central factors in ensuring coherent care experiences. Overall, continuity of care in all its forms played a significant role in creating coherent care journeys.

Our finding of the importance of relational continuity corresponds with findings in previous studies. In general, continuity of midwifery care is found to facilitate woman-centred care and serves as a platform for establishing trust, engagement and empowerment [35–37]. McCourt and Stevens similarly established that relational continuity enables midwives to provide individualised care as a result of in-depth familiarity with the woman and her partner [38]. Our study also found that parents saw it as significant that the professionals were familiar with them and trusted that this facilitated the right care and support. Many parents in a vulnerable position worry about being judged by professionals [27]. They will often find it difficult to engage with services and harbour mistrust due to previous difficult or traumatic experiences [23]. Recent studies have also found that it is difficult for women to disclose mental health problems during the perinatal period if they do not know and trust the professional [39,40]. The opportunity to develop a trusting relationship over time is therefore key to feeling comfortable and secure in healthcare encounters [22,24,41,42].

The need for continuity stretches beyond simply knowing and being known by the same carer. Balaam and Thomson found that while vulnerable women in general value relational continuity during pregnancy, to others the type of care they receive is more important [24]. In a previous paper, we reported that the professionals' competencies are paramount to a positive and supportive care experience [28]. Parents feel secure, respected and included when they sense that professionals listen to them, show understanding and take them seriously while being non-judgemental and reassuring [28]. This finding is supported by other studies that have highlighted the importance of the quality of the interaction and the professionals' approach [21–24,41,43]. Whereas our study findings fully support the existing literature as to the key role of relational continuity, it is a further prerequisite for developing trusting relationships that parent–professional encounters are experienced as supportive.

Our findings show that it is essential that information is shared among providers and services. A study found that fragmented communication between maternity care and child health professionals risk compromising the quality of the care provided, whereas effective transfer of information can facilitate the support of parents and provide appropriate and timely care [44]. Another study found that discontinuity of information between midwives and health visitors leave women feeling they are not being listened to; they prefer not having to repeat themselves, particularly in relation to labour, mental health problems and chronic conditions [45]. Such situations may be even more difficult for women with a history of traumatic or painful experiences that it may be stressful to revisit [43]. Transfer of information through electronic medical records or other administrative and handover processes contribute to giving parents a sense of being known and remembered across services and providers without having to share their needs and life situation to each new provider encountered. Conversely, as our study shows, transfer of information can leave parents feeling vulnerable or exposed. Olander et al. found that some women were reluctant about information being shared as the health visitor was associated with child safeguarding services [45]. Importantly, as parents in a vulnerable

position may carry painful experiences of stigmatisation or lack of understanding, they may be distressed about being judged by professionals and worry about the potential negative consequences of being candid or accepting services [27]. Transfer of information to help ensure a coherent care journey is thus contingent on how and why information is being shared as well as on how parents experience this.

For parents to experience coherent care, it is essential that they have access to and are referred to relevant and flexible services that match their needs for timely support. Recommendations have been made for the routine screening of all women in pregnancy and following birth to identify psychosocial vulnerabilities, including mental health problems, to ensure early referral to services [7]. This should be supported by appropriate referral pathways and models of care to ensure that parents have access to relevant and timely support to avoid potential negative implications for the family's health and wellbeing [7,9]. Our findings demonstrate that vulnerable parents experience the care as fragmented if they perceive a gap between their needs and what is offered. In the case of perinatal mental health services, recent studies have identified a number of such experiences [46,47]. Unclear referral pathways prevent midwives from effectively linking women who suffer from depression with mental health services [46]. Also, fragmented models make it difficult for midwives to know the woman, identify any subtle changes and recognise her needs for mental health services [47]. Moreover, organisational factors and the lack of resources, specialist services, or long waiting lists likewise lead to fragmented care [47].

Improved coordination to ensure continuity of services, for example in the transition between midwifery and health visiting or community health nursing services, is vital to avoid fragmented care due to poor communication, lack of cooperation and overlapping responsibility for care [44,48]. As parents with complex needs often require support beyond maternity care, our study considered the transition of care extend beyond a collaboration between midwifery and health visitors, although in many instances that would be a good starting point. Coordination is important to link families with other services in the community, such as mental health services or supportive parenting interventions. This requires that professionals have sufficient knowledge of the different care pathways. According to a 2017 study, professionals in child and family health services can act as the bridge between services, some of whom may be in a liaison role, which can potentially increase continuity of care by ensuring that information is shared and that parents are referred to relevant services matching their current need for support [49].

The coordination of care for vulnerable parents requires insight into their challenges, life situation and support needs. This may be ensured by transfer of information among services and providers as well as by relational continuity. With professionals playing a central role in identifying a family's need for support and in referral to services [8], relational continuity allows them to gradually accumulate knowledge of the family. Rayment-Jones et al. [20] found that relational continuity enables a midwife to become a key stakeholder in the care of women. By helping them navigate a complex maternity care system, the midwives ensured referral to appropriate services [20], illustrating that all types of continuity are closely interwoven as informational continuity also includes the accumulation of knowledge about individual preferences and values through ongoing encounters with a professional who is known by the woman [12]. The assignment of one or a limited number of professionals can help parents approach the relevant services when they need support and feel secure in doing so.

7.1. Study implications

The results of our study demonstrate the need to prioritise all aspects of continuity of care in the organisation of maternity care services for parents in a vulnerable position. Continuity of midwifery care is strongly recommended for women and their families at risk of poor outcomes. It is further recommended that women are linked to one health visitor with

whom they are familiar to support the development of a relationship, which may begin in pregnancy to ensure continuity when discharged from maternity services. To achieve this, professionals need skills and training in supporting vulnerable women and their partners in navigating the complex field of multiple actors and sectors to ensure that both information and management continuity are accomplished. Our findings underline the importance of relevant and easily accessible services that can help parents access relevant and timely help. At an organisational level this requires that a wide array of evidence-based services is available to match the diverse needs of a heterogeneous group. To evaluate how best to facilitate continuity and identify facilitators and potential barriers in organising this form of care, further research is needed, including the exploration of the perspectives of midwives, health visitors and other professionals involved in caring for vulnerable parents during pregnancy and the postnatal period.

7.2. Study strengths and limitations

A strength of this study is the inclusion of participants with different sociodemographic backgrounds and vulnerability factors. The ethnographic design allowed for a large set of in-depth data to be generated as well as for participants to be followed over time. However, the study has some limitations. Our recruitment criteria included participants that engaged with services or professionals; however, this may mean that participants not engaged with services and who had highly negative experiences may have been left out. We also relied a lot on health professionals smoothing the way to introduce us to potential participants and therefore their perspective of who would make a 'good' participant may have influenced the parents that the first author was introduced to. Moreover, as recruiting mothers for the study was easier than recruiting partners, the data set is gendered because of the preponderance of interviews, field visits and time spent with the recruited mothers. Following this, in the analysis limited data on the fathers' perspectives have been presented.

8. Conclusion

This study contributes in-depth knowledge on the role of continuity of care for vulnerable parents during pregnancy and the postnatal period. In line with previous research, our study demonstrates that being cared for by familiar care providers is critical to building trust and enabling parents to feel secure in reaching out for support and to their openness in discussing their challenges. At the same time, continuity facilitates individualised care based on the professionals' knowledge of families' needs, which is highly appreciated by parents. The study establishes that vulnerable parents' experience of coherent care is contingent not only on relational continuity. It is also important that the handover of information is ensured when parents transit between services, providers and sectors. To avoid parents having to retell their stories and to ensure that their support needs are recognised by all professionals, strong communication and collaboration is required. Professionals need to be aware that transfer of information can provoke worry and insecurity in parents. Moreover, for parents to experience coherent care, it is essential that they have access to and are referred to relevant and flexible services that match their current needs for support. This requires smooth and easy navigation of referral pathways for both professionals and parents. In conclusion, different aspects or forms of continuity of care must be given high priority in the organisation of maternity care services for parents in a vulnerable position.

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Ethical statement

The research project was carried out in accordance with Danish legislation (The National Committee on Health Research Ethics, 2018), and the Declaration of Helsinki (The World Medical Association, 2013). In Denmark, qualitative research is solely based on participant informed consent and cannot be submitted for ethical approval by a scientific committee (The National Committee on Health Research Ethics, 2018). The parents' informed consent was collected after they had been informed of the research project verbally and in writing. To ensure confidentiality and anonymity data were handled to ensure the integrity of participant. Pseudonyms were used in the analysis. The study is listed with the Danish Data Protection Agency (Record No. 2019-899/10-0020).

Conflicts of interest

The authors declare no conflicts of interests. The funders played no role in the research design, analysis and interpretation of data, preparation of the manuscript or the decision to submit the manuscript for publication.

Author contributions

Authors MSF, VS and CO jointly conceptualised and designed the study. MSF recruited participants, performed data collection, analyses and interpretation of results and drafted the article. Throughout the process, all authors discussed all parts of the manuscript, including coding, initial themes as well as the reporting and discussion of results and study conclusions and implications. VS and CO made substantial contributions to the manuscript as they critically commented on and contributed to revise the manuscript at all stages of the process. All authors have read and approved the final version of the manuscript for submission.

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