Identifying Barriers and Enablers as a First Step in the Implementation of a Midwife-Led Psychoeducation Counseling Framework for Women Fearful of Birth

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BACKGROUND: Around 20% of women report high levels of childbirth fear. An evidence-based psychoeducation intervention delivered by midwives reduced maternal childbirth fear and increased confidence for birth. Implementation of the intervention into practice is now required. Translating evidence into practice, however, remains challenging.

AIM: This study aimed to explore organizational factors, including barriers and possible solutions that may impact on the successful application of the midwife psychoeducation intervention in practice.

METHODS: Mixed methods data collection included a self-administered survey ($n = 62$), clinician-led focus groups ($n = 28$), and interviews with key stakeholders ($n = 5$). Simple descriptive statistics were used to analyze the quantitative data. Latent content analysis was used to analyze the qualitative data.

RESULTS: Midwives were perceived to be best placed to deliver psychoeducation to women fearful of birth. Support for normal birth was high. There was, however, disparity between positive attitudes toward evidence-based practice in theory and its clinical application. Similarly, although the workplace learning culture was generally assessed as positive, many participants believed changing practice was difficult and reported a low sense of agency for challenging or facilitating change. Participants reported that barriers to implementing the evidence included time constraints and heavy workloads. There was a lack of awareness and confidence to implement evidence-based practice (EBP) with participants identifying that resistance to change was often the result of clinician fear and self-interest. The way services were routinely structured was considered problematic as fragmentation actively worked against midwives forming meaningful relationships with women. Enablers included organizational support, education, local champions, and continuity of midwifery care.

CONCLUSION: The study identified the clinicians' readiness, barriers, and possible solutions to the widespread implementation of an evidence-based psychoeducation intervention delivered by midwives for women fearful of birth at one maternity facility in South East Queensland, Australia. Many of the identified barriers were commensurate with the international literature on translating evidence into practice.

KEYWORDS: midwives; childbirth fear; psychoeducation; knowledge translation; research use; evidence-based practice

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INTRODUCTION

Childbirth fear is relatively common in developed countries, such as Australia with approximately 20% of women reporting some level of fear (Fenwick et al., 2013; Lukasse, Schei, & Ryding, 2014). Fearful women are more likely to experience anxiety, depression, and stress as well as isolation and poor social support (Räisänen et al., 2014; Toohill et al., 2014). Of increasing concern is the association with increased birth intervention, particularly cesarean section (Fenwick, Gamble, Nathan, Bayes, & Hauck, 2009; Fenwick, Staff, Gamble, Creedy, & Bayes, 2010; Haines, Rubertsson, Pallant, & Hildingsson, 2012; Ryding, Wijma, Wijma, & Rydhström, 1998; Saisto & Halmesmäki, 2007) and poor maternal emotional well-being postpartum (Boorman, Devilly, Gamble, Creedy, & Fenwick, 2014; Parfitt & Ayers, 2009). Mood disorders in new mothers contribute to poor family functioning and disturbances to healthy child development (Grekin & O'Hara, 2014).

In a recent randomized controlled trial, Australian researchers demonstrated that a brief psychoeducation intervention delivered by trained midwives was effective in reducing high childbirth fear levels ($p < .001$) while also increasing confidence for birth ($p = .002$). The intervention for women reporting high childbirth fear included the provision of psychoeducational counseling over the telephone by trained midwives at two time points (Fenwick et al., 2013). Results also demonstrated a clinically meaningful overall reduction (8%) in cesarean section rates (Fenwick et al., 2015). In addition, economic analysis revealed that the intervention did not increase costs (Turkstra et al., 2017). Given the positive nature of the findings, the next step in the research process was to translate the evidence into midwifery practice, enabling universal access to the intervention by women in need.

Integration of research findings into clinical practice to improve health care outcomes is associated with improved patient safety and clinician job satisfaction as well as decreased health service use (Fairbrother, Cashin, Conway, Symes, & Graham, 2016). However, it has long been recognized that translating evidence into clinical practice, also commonly referred to as *knowledge translation* (Sudsawad, 2007), can be challenging (Green, 2014; Grimshaw, Eccles, Lavis, Hill, & Squires, 2012; Miller, 2016; Pierson, 2009). Over the last decade, there has been an increasing drive and focus on the implementation of evidence into practice.

Knowledge translation is a process consisting of several separate events (Oborn, Barrett, & Racko, 2013; Rich, 1991). Evaluating knowledge translation can prove difficult without using a systematic approach. Although several conceptual models have been developed, we employed Conner's conceptual model for research use evaluation. The model provides a good fit for a research translation framework because it considers goals, inputs, processes, and outcomes (Sudsawad, 2007).

This article reports on part of a larger knowledge translation evaluation project (outlined in Figure 1). As a first step in the process of implementing the psychoeducation counseling intervention, referred to as BELIEF (Fenwick et al., 2013; Toohill et al., 2014; outlined in Figure 2), the team explored possible organizational factors that may influence the translation of new evidence into midwifery practice as well those that might be specific to BELIEF. The research objectives of this phase were therefore to

- Identify clinicians' perceptions about the appropriateness of midwives to support and address a range of psychosocial issues in pregnant women including childbirth fear;
- Explore clinicians' perceptions of their role and confidence in preparing women to have a normal birth including those with fear;
- Identify clinicians' beliefs and confidence around evidence-based practice (EBP);

Phase	Aim	Data Collection
1	Explore possible organizational factors that may influence the translation of new evidence into midwifery practice as well as those that might be specific to BELIEF.	Survey Focus groups Interviews
2	Implement and evaluate the BELIEF training program in terms of (1) midwives' knowledge, skills and confidence to provide psychoeducation counselling; (2) perceived barriers and enablers to embedding the BELIEF midwifery counselling framework in practice; and (3) change to women's fear levels.	Pre-post training survey Diaries Interviews Clinical audit data (fear of birth scores)

FIGURE 1 Research evaluation project - Midwives Improving care through Psychoeducation in Practice (The MIPP Project).

Strategies
Develop therapeutic relationship with the woman
Work with women's perceptions of childbirth and maternity services
Support expression of feelings
Connect emotions and beliefs with the woman's view of childbirth or world view/prior birth experiences / or reproductive events
If applicable - review prior birth related events
Promote positive expectations / anticipation around the upcoming birth event
Promote positive approaches to birth planning
Enhance ongoing social support

FIGURE 2 Summary of the key strategies/elements of the BELIEF counselling framework (2,4).

- Assess organizational learning culture/readiness for implementing new evidence; and
- Examine and describe barriers and possible solutions to integrating the BELIEF psychoeducational counseling intervention into midwifery practice.

METHODS

The evaluation project used a mixed methods approach which included a survey, clinician-led focus groups, and interviews with key members of the service leadership team.

Setting

The study took place at a publically funded maternity unit in South East Queensland. At the time the study commenced, the unit was providing care to approximately 4,600 childbearing women per year with most women receiving standard fragmented care within a consultant-led unit. Continuity of midwifery care (caseload) was available to a limited number of women (approximately 10%). Other than general practitioner (GP)-shared care and obstetric high-risk care, pregnancy care was generally provided by midwives.

Participants

A convenience sample of the multidisciplinary maternity team ($N = 190$) were invited to participate in a self-administered survey. The team included approximately 150 midwives, 25 obstetric staff, and 15 allied health staff. Sixty-two participants completed the survey. In addition, 28 clinicians were invited to and participated in one of seven focus groups. Finally, five leaders within the service were interviewed (two specialist doctors, the service director, and two midwife managers).

Recruitment

In-service sessions were held for staff to provide an overview of the study and promote staff participation. Information sheets, consent forms, and surveys were made available at this time as well as forms being left in each clinical area. Attendance at multidisciplinary education events, meetings with organizational leaders, and an article in the hospital's maternity division newsletter also provided an opportunity to inform and recruit staff to participate in the study.

Survey

Measures

DEMOGRAPHIC INFORMATION. Participants were asked to provide their age, years of experience, highest qualification, employment details, and clinical area.

PSYCHOSOCIAL CARE PROVIDER. Given the fragmentation of service provision that is a common feature of the Australian maternity landscape, we considered it important to firstly ascertain participant's opinions on the most appropriate persons to assess fear of birth and psychosocial risk, and provide psychoeducation as a first response to childbearing women. Fear of birth can be related to one or a combination of psychosocial risk factors such as experiencing intimate partner violence, unresolved grief, and/or a lack of social support. In line with best practice, outlined in the *Perinatal Clinical Guidelines for Depression and Related Disorders* (beyondblue, 2011), all women were asked a series of questions to detect the presence of psychosocial risk (such as alcohol and drug use, mental health condition and/or domestic violence, relationship problems, social support, parenting/mothering, stress, and unresolved grief). Using a dichotomous response (yes/no), seven possible responses were provided (midwife, GP, hospital medical staff, mental health nurse, psychologist, social worker, and not sure/other). Using the same list of 10 psychosocial issues, respondents were then asked to rate their confidence to address and counsel women

about these issues (1 = *not confident at all*, to 5 = *very confident*). Specifically, respondents were asked if they thought midwives have the necessary knowledge or skills to address women's psychosocial issues (yes/no).

BIRTH OPTIONS. Participants rated their level of confidence (1 = *confident* to 10 = *not confident*) about (a) advising a woman about her birth options and (b) providing care in labor. Using a similar Likert scale (1 = *not worried* and 10 = *extremely worried*), respondents rated their concern about (a) advising a woman about her birth options and (b) providing care in labor.

SUPPORT FOR NORMAL BIRTH AND WOMEN WITH FEAR. Participants were asked to rate their support for normal birth (1 = *strongly disagree* to 5 = *strongly agree*) and extent to which women should be supported to achieve (a) a normal birth and (b) a positive emotional birth experience. The same questions were also asked in the context of supporting fearful women.

EVIDENCE-BASED PRACTICE. The Adapted Evidence-Based Practice Beliefs Scale (A-EBP-B) originally developed by Melnyk, Fineout-Overholt, and Mays (2008) and revised by Abrahamson, Arling, and Gillette (2013) was used to measure beliefs and confidence for implementing EBP. A Cronbach's alpha of .71 was achieved in this study which is less than levels reported previously (.86–.90) but still considered acceptable (Pallant, 2011).

CULTURE SUPPORTIVE OF LEARNING. The Clinical Learning Organisational Culture Survey (CLOCS) was used to measure participants' beliefs and assumptions for learning in the workplace (Henderson, Creedy, Boorman, Cooke, & Walker, 2010). The 28-item tool measures five key concepts. "Recognition" is the importance and effectiveness of reward/feedback systems operation within the organization (11 items—*I have a say in what happens here*). "Dissatisfaction" equates to the overall discontentment with the workplace (6 items—*We are not rewarded when we do a good job*). "Affiliation" measures the need and opportunities for interaction within the organization (4 items—*We work as a team here*). "Accomplishment" is the self-imposed and organization-level performance standards (4 items—*I really believe in the value of what I am doing*). "Influence" measures the effects of power and competition within the organization (3 items—*Maternity health professional's views are ignored in this health facility*). Henderson et al. (2010) reported good internal consistency measures of reliability using Cronbach's alpha (α) for Recognition (α = .91), Dissatisfaction (α = .77), Affiliation (α = .80), and Accomplishment (α = .66) but less so for Influence (α = .53). Our study identified a Cronbach's alpha (α) for Recognition (α = .91), Dissatisfaction (α = .77), Affiliation (α = .87), and Accomplishment (α = .66), but the domain of Influence was deemed to be less reliable (α = .43).

BARRIERS AND ENABLERS. Last, respondents reported on perceived relevance and possible solutions to implementing BELIEF. The four potential barriers to EBP identified by the Cochrane Effective Practice and Organisation of Care Group (EPOC; lack of time, lack of awareness of evidence, unsure how to implement the evidence, and resistance to change) provided the framework for the open-ended questions (EPOC, 2012). Participants were asked to indicate whether they considered the potential barrier to be relevant and if so, what might be a possible solution. Participants could also nominate "other" potential barriers.

Quantitative Data Analysis

Quantitative data were entered into SPSS Version 22. Descriptive statistics and frequencies were used to describe participant characteristics. Scales (EBP-B, CLOCS) were tested for reliability using Cronbach's alpha. The eight negative items of the CLOCS were reverse scored. As suggested by Henderson et al. (2010), composite variables for all subscales were created by computing the mean across the associated items for Recognition, Dissatisfaction, Affiliation, Accomplishment, and Influence.

Focus Groups and Interviews

Participants

Seven focus groups were conducted over a 2-week period. Attendance at each focus group session fluctuated (0–11) with 28 participants (n = 18 antenatal clinic, n = 5 birth suite, n = 0 maternity ward, n = 5 workshop). All attendees were midwives. Five service leaders were interviewed and included two specialist doctors, the service director, and two midwife managers. Interviews lasted on average 27 min (range = 15–51 min).

Procedure

Focus groups sessions on the maternity ward and birth suite were conducted at set times at crossover of shifts when more staff were available. Antenatal clinic

focus groups were conducted during protected in-service sessions. Sessions lasted approximately 21 min (range = 0–30 min), were digitally recorded and transcribed using a professional transcribing company. Questions focused on eliciting participants perceptions of the organizational factors, including barriers and enablers, to midwives being able to integrate and apply the BELIEF intervention to address fear in pregnant women in practice (see Figure 2 for a summary of the BELIEF framework).

Data Analysis

Qualitative data were generated from open-ended questions on the survey (n = 55), focus groups, and interviews. Latent content analysis was used to elicit the underlying meaning of content focusing on rich description (Polit & Beck, 2012).

Digitally recorded interviews and focus groups were transcribed verbatim with the open-ended survey responses being transcribed into a word document. Transcripts were read and reread to create a sense of immersion in the data set. Line-by-line coding then commenced with keywords, phrases, and/or sentences highlighted. Like concepts were grouped together and constantly compared until clear themes emerged. Three researchers undertook the analysis. Audit trails were used to share decision making with the rest of the team.

ETHICAL CONSIDERATIONS

Ethics approval was obtained from Griffith University and Gold Coast Health Service District Human Research Ethics committees. The survey was anonymous. The focus groups and interview data were de-identified with only the facilitators aware of participants' identity. Consent forms were kept in a separate secure location to the transcripts. Confidentiality was maintained through the use of unique identifiers.

RESULTS

Participant Characteristics

Sixty-two maternity health professionals completed the organizational survey (32.6% response rate). The majority were female (n = 57, 91.9%) and midwives (n = 49, 79.0%). Two were student midwives. The average age of participants was 43.1 years (SD = 12.8) with 16.8 (SD = 12.7) years' experience (range = 1–45 years). Fifty-nine (95.2%) participants worked as clinicians. See Table 1 for demographic details.

Responding to Fear and Psychosocial Risk in Pregnancy

Most participants considered that addressing psychosocial issues in pregnancy was the role of maternity professionals (n = 57, 91.9%) with the midwife considered best placed to provide support across multiple issues. However, nearly half of respondents lacked confidence to counsel women in the areas of domestic violence (n = 25, 43.9%), illicit drug use (n = 28, 49.1%), and unresolved grief (n = 24, 42.1%). Maternity providers stated they were most confident to counsel women about parenting/mothering (n = 42, 73.7%) and fear of birth (n = 37, 64.9%). Refer to Table 2.

Most participants (n = 53, 93%) considered that addressing childbirth fear was the specific domain of midwives, and they should have the knowledge and skills to do this (n = 49, 86%). Furthermore, almost all (n = 53, 93%) agreed or strongly agreed that midwives should provide psychoeducation to women with a fear of birth. Only half the respondents (n = 28, 49.1%), however, believed that midwives currently had the necessary knowledge and skills to competently address women's concerns.

Normal Birth and Confidence to Facilitate Normal Birth in Fearful Women

Supporting women to achieve a normal birth is a key strategy in reducing unnecessary intervention and promoting physical and emotional well-being during the transition to motherhood (Cheyne, Abhyankar, & McCourt, 2013; Marshall, Spiby, & McCormick, 2015; "Supporting Healthy and Normal Physiologic Childbirth," 2013). All but one participant agreed or strongly agreed that women should be supported to achieve a normal birth (n = 57, 98.3%). Similarly, all agreed or strongly agreed that women should be supported to achieve a positive emotional birth experience (n = 58, 100.0%).

Most were confident (n = 49, 84.5%) and unconcerned (n = 57, 98.3%) about advising women of their birth options. Fewer respondents reported being confident (n = 42, 72.4%) and unconcerned (n = 47,

TABLE 1 Demographics of Staff ($N = 62$)

	n	%	*M (SD)*	RANGE
Gender				
Female	57	91.9		
Male	4	6.5		
Missing	1	1.6		
Age (years)			43.1 (12.8)	21–73
Years in profession			16.8 (12.7)	1–45
Professional group				
Midwife	33	53.2		
Nurse/midwife	16	25.8		
Student midwife	2	3.2		
Neonatal nurse	1	1.6		
Mental health nurse	1	1.6		
Endorsed enrolled nurse	1	1.6		
Local medical officer	1	1.6		
Obstetric registrar	2	3.2		
Obstetrician	2	3.2		
Neonatologist	1	1.6		
Social worker	1	1.6		
Missing	1	1.6		
Employment Category				
Grade 5 midwife	31	50.0		
Grade 6 midwife	17	27.4		
Grade 7 midwife or above	2	3.2		
Registrar	2	3.2		
Consultant	4	6.5		
Unpaid	2	3.2		
Missing	4	6.5		
Main professional role				
Clinical	59	95.2		
Education	1	1.6		
Admin/management	1	1.6		
Missing	1	1.6		
Principal area of work				
Antenatal only	9	14.5		
Labor and birth only	16	25.8		
Postnatal only	5	8.1		
Neonatal only	5	8.1		
Caseload–public	2	3.2		
Caseload–private	1	1.6		
Antenatal and postnatal	3	4.8		
Antenatal and intrapartum	1	1.6		
Postnatal and intrapartum	1	1.6		
Across all areas	13	21.0		
Breast screening	1	1.6		
Perinatal mental health	1	1.6		
Obstetric care	2	3.2		
Specialist	1	1.6		
Missing	1	1.6		

(Continued)

TABLE 1 Demographics of Staff ($N = 62$) *(Continued)*

	N	%	*M (SD)*	RANGE
Highest qualification				
Certificate	12	19.4		
Diploma	3	4.8		
Bachelor degree	28	45.2		
Postgrad diploma	5	8.1		
Master's degree or above	11	17.7		
Medical degree	2	3.2		
Missing	1	1.6		
Country of primary qualification				
Australia	48	77.4		
New Zealand	2	3.2		
United Kingdom	10	16.1		
Missing	2	3.2		

81%) about providing care in labor. Similar results were achieved in relation to women with birth fear albeit at slightly lower rates (confident $n = 47$, 81%; concern $n = 49$, 84.5%). Interestingly, respondents were more positive about providing labor and birth care for fearful woman (confident $n = 46$, 79.3%; concerned $n = 46$, 79.3%).

Confidence Implementing Evidence-Based Practice

The majority believed EBP resulted in the best clinical care ($n = 51$, 92.7%) and improved clinical care ($n = 42$, 76.4%). Although most respondents believed their care was evidence-based ($n = 50$, 91%), only half reported that they could search for best evidence to answer clinical questions in a time efficient way ($n = 32$, 58.2%) or felt able to overcome barriers to implementing EBP ($n = 30$, 54.5%). Similarly, less than half believed they have the knowledge to implement EBP sufficiently to make practice changes ($n = 25$, 45.5%) and little more than a half felt confident in their ability to implement EBP where they worked ($n = 31$, 56.4%). Only a third were sure how to measure the outcomes of their clinical care ($n = 17$, 30.9%; Table 3).

Workplace Readiness

Respondents rated the CLOCS domain of Accomplishment highest ($M = 16.6$, $SD = 2.02$; refer to Table 4). All but one respondent reported feeling proud of their work ($n = 55$, 98.2%) with most really believing in the value

TABLE 2 How Confident Do You Feel to Address and Counsel Women About the Following: ($N = 57$)

	NOT CONFIDENT		SOMEWHAT UNDER CONFIDENT		NEITHER CONFIDENT OR UNDER CONFIDENT		CONFIDENT		VERY CONFIDENT		MISSING	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
1. Domestic violence	5	8.8	20	35.1	16	28.1	13	22.8	3	5.3	0	0
2. Illicit drug use	2	3.5	26	45.6	17	29.8	9	15.8	3	5.3	0	0
3. Alcohol use	2	3.5	16	28.1	16	28.1	20	35.1	3	5.3	0	0
4. Common perinatal mental health disorders	3	5.3	14	24.6	16	28.1	22	38.6	2	3.5	0	0
5. Relationship problems	4	7.0	15	26.3	25	43.9	12	21.1	1	1.8	0	0
6. Social support	4	7.0	12	21.1	19	33.3	21	36.8	1	1.8	0	0
7. Parenting/mothering	0	0	9	15.8	6	10.5	22	38.6	20	35.1	0	0
8. Stress	2	3.5	11	19.3	16	28.1	23	40.4	4	7.0	1	1.8
9. Fear of birth	0	0	10	17.5	9	15.8	23	40.4	14	24.6	1	1.8
10. Unresolved grief	7	12.3	17	29.8	15	26.3	14	24.6	3	5.3	1	1.8

TABLE 3 Evidence–Based Practice–Belief ($N = 55$)

	STRONGLY DISAGREE		DISAGREE		NEITHER AGREE NOR DISAGREE		AGREE		STRONGLY AGREE		MISSING	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%	*n*	%
1. I believe that EBP results in the best clinical care for women and babies	0	0	1	1.8	3	5.5	30	54.5	21	38.2	0	0
2. I am sure that evidence-based guidelines can improve clinical care and outcomes for women and babies	2	3.6	2	3.6	9	16.4	20	36.4	22	40.0	0	0
3. I believe I can search for the best evidence to answer clinical questions in a time efficient way	2	3.6	6	10.9	15	27.3	24	43.6	8	14.5	0	0
4. I believe I can overcome barriers in implementing EBP	0	0	5	9.1	19	34.5	26	47.2	4	7.3	1	1.8
5. I am sure I can implement EBP in a time efficient way	0	0	5	9.1	10	18.2	33	60.0	6	10.9	1	1.8
6. I am sure that implementing EBP will improve the care that I give to women	1	1.8	7	12.7	6	10.9	27	49.1	14	25.5	0	0
7. I am sure about how to measure the outcomes of clinical care	3	5.5	18	32.7	17	30.9	14	25.5	3	5.5	0	0
8. I believe EBP takes too much time	7	12.7	28	50.9	17	30.9	2	3.6	1	1.8	0	0
9. I believe EBP is difficult	3	5.5	22	40.0	15	27.3	13	23.6	2	3.6	0	0
10. I know how to implement EBP sufficiently enough to make practice changes	0	0	12	21.8	18	32.7	24	43.6	1	1.8	0	0
11. I am confident about my ability to implement EBP where I work	0	0	9	16.4	15	27.3	28	50.9	3	5.5	0	0
12. I believe my care is evidence based	0	0	1	1.8	4	7.3	37	67.3	13	23.6	0	0

TABLE 4 CLOCS–Work Environment ($N = 56$)

	DISAGREE (STRONGLY DISAGREE & DISAGREE COMBINED)		NEITHER AGREE NOR DISAGREE		AGREE (STRONGLY AGREE & AGREE COMBINED)		MISSING	
	n	%	*n*	%	*n*	%	*n*	%
Affiliation								
1. Maternity health professionals at my hospital strive for excellence (Affiliation)	2	3.6	13	23.2	40	71.4	1	1.8
2. We work as a team here (Affiliation)	6	10.7	8	14.3	42	75.0	0	0
3. The quality of work is important here (Affiliation)	2	3.6	5	8.9	49	87.5	0	0
4. Maternity health professionals help each other to get the job done (Affiliation)	4	7.1	9	16.1	43	76.8	0	0
Accomplishment								
5. I am clear about what is expected of me as a member of the maternity team (Accomplishment)	2	3.6	5	8.9	49	87.5	0	0
6. I am proud of my work (Accomplishment)	1	1.8	0	0	55	98.2	0	0
7. I really believe in the value of what I'm doing (Accomplishment)	1	1.8	2	3.6	53	94.6	0	0
8. I am able to balance all the requirements of my role (Accomplishment)	6	10.7	15	26.8	35	62.5	0	0
Influence								
9. Maternity health professionals views are ignored at this health facility (Influence)	36	64.3	12	21.4	8	14.3	0	0
10. You need to have a position of power to have any influence around here (Influence)	18	32.1	16	28.6	22	39.3	0	0
11. People don't take advantage of their senior position in this hospital (Influence)	23	41.1	23	41.1	10	17.9	0	0
Dissatisfaction								
12. It is difficult to get help when I need support and advice (Dissatisfaction)	32	57.1	13	23.2	11	19.6	0	0
13. We are not rewarded when we do a good job (Dissatisfaction)	19	33.9	16	28.6	21	37.5	0	0
14. Maternity health professionals in the unit are worried about making mistakes (Dissatisfaction)	9	16.1	22	39.3	25	44.6	0	0
15. I receive little feedback about what I do (Dissatisfaction)	21	37.5	15	26.8	20	35.7	0	0
16. Changing practice in this unit is difficult (Dissatisfaction)	10	17.9	21	37.5	24	42.9	1	1.8
17. There is little or no acknowledgement about the quality of my work (Dissatisfaction)	18	32.1	22	39.3	16	28.6	0	0
Recognition								
18. My contribution is recognised (Recognition)	8	14.3	13	23.2	35	62.5	0	0
19. In our unit we are encouraged to try new things (Recognition)	11	19.6	15	26.8	30	53.6	0	0
20. I feel that I am important (Recognition)	6	10.7	27	48.2	23	41.1	0	0
21. Maternity health professionals in this unit learn from each other (Recognition)	4	7.1	11	19.6	41	73.2	0	0
22. Maternity health professionals are well supported (Recognition)	11	19.6	15	26.8	30	53.6	0	0
23. I feel as if I'm listened to here (Recognition)	8	14.3	19	33.9	29	51.8	0	0
24. I am encouraged by my co-workers to do my best work (Recognition)	3	5.4	14	25.0	39	69.6	0	0
25. I have a 'say' in what happens here (Recognition)	15	26.8	19	33.9	22	39.3	0	0
26. My opinion is valued (Recognition)	8	14.3	25	44.6	23	41.1	0	0
27. My co-workers are supportive of my professional development (Recognition)	7	12.5	16	28.6	33	58.9	0	0
28. It is clear that my job is important to the success of the hospital (Recognition)	3	5.4	20	35.7	33	58.9	0	0

of what they are doing (n = 53, 94.6%). Respondents were less likely to feel able to balance the requirements of their role (n = 35, 62.5%). The domain of Affiliation (M = 15.72, SD = 2.78) also scored highly. The majority of participants felt the quality of work was important (n = 49, 87.5%), and three quarters believed everyone strives for excellence, works as a team, and helps each other to get the job done. There was, however, a level of participant Dissatisfaction (M = 17.9, SD = 4.0). Receiving limited acknowledgment, reward or feedback fell into this category. Most considered changing practice to be difficult (n = 46, 80%). Just under half of participants (n = 25, 44%) stated that clinicians in their unit worried about making a mistake.

The domain of Influence produced mixed results (M = 9.13, SD = 2.19), which could have contributed to poor reliability. Although 34 (64%) participants felt heard, around a third reported "being ignored." Likewise, 22 (39.3%) participants believed that a position of power was needed to influence change (Table 4).

Barriers and Possible Solutions to Using the BELIEF

Fifty-five participants offered responses regarding perceived barriers and solutions to midwives integrating the BELIEF intervention in practice. The qualitative findings from all sources mirrored each other closely and have been integrated in the following text.

Lack of Time—"Under the Pump"

Forty-four (80%) respondents considered lack of time as an implementation barrier. Likewise "time pressures" also featured strongly in the focus group data but to a lesser extent in the interview data. In what was described as an "already busy work-day," participants were concerned about not being able to provide enough time to meet pregnant women's individual needs. Those working in the antenatal area constantly spoke of "strict time lines," "time constraints," and being "very busy." One midwife summarized the wide variety of topics discussed during an antenatal visit: "In a maximum of, what, 10 min, not even that, you're covering everything from how she's feeling, how she's coping with things, how she's sleeping . . . . " Other midwives added the following topics: "You've got to do your whooping cough" and "Anti D and your birth plan," "breast feeding" and "ultrasounds," and "check the pathology" and "then your actual physical examination. It's huge!"

Continued increases in work-related activity also fueled constraints on clinicians' time. Trying to implement change within the maternity health care context described as a "pressure cooker" was considered problematic by one interviewee. Dealing with the immediate tasks at hand was seen as the "top priority" by some rather than focusing on any proposed change to practice.

> *There's only so much people can take, and I think if they're busy on the floor, which my guys are at the moment because the birth rate's gone up by 400, and we haven't got any more resourcing for that . . . so trying to manage that and make sure that they're coping with the day to day stuff . . . never mind, "Oh this is what we're going to be doing in the future." Your mind's not actually going to be focused on that. You're going to be focused on the here and now.*

Potential solutions pertaining to "lack of time" and ensuring successful implementation of the psychoeducational counseling included increasing staff, having more time for clinic visits, and extra nonspecific resources. Although organizational solutions were stated as improving shift patterns, support from doctors and reducing document duplication perhaps the most important enabler was considered to be offering one-to-one care by a "known" midwife to all women. Continuity of midwifery care was seen as making everything "a lot easier." Within the context of an ongoing relationship with an individual woman midwives said they could not only identify a woman's needs but have the time to work in partnership with them, across the pregnancy using the psychoeducational counseling, to address them in the most appropriate way.

The Evidence—"What Does It Mean and How to Use It?"

A large number of survey participants (n = 44, 80%) felt "not being aware of the evidence" was a barrier that might inhibit midwives from providing psychoeducation to fearful women. In addition many (n = 42, 76.4%) felt that midwives would be unsure of how to put the evidence into practice.

Focus group and interview data supported the survey results with one interviewee stating, "I think a barrier certainly with obstetricians is a lack of awareness of the evidence, lack of understanding. What does

it mean?" Another clinician paired the lack of awareness with insufficient resources: "People not being aware of the evidence, and lack of guidelines surrounding the evidence . . . lack of good resources that are easily accessible for clinicians to use and share, like guidelines, or patient info brochures." Easy availability of reliable information was seen as important. Most suggested solutions focused on ensuring educational opportunities were made available to midwives and student midwives. Providing ongoing support was also considered important.

In addition, effective communication was seen as an essential part of enabling the uptake of the psychoeducational counseling. Ensuring clinicians had access to the evidence around the benefits of the intervention was a strong theme in both the survey and focus group data. Included in this was making sure "research" was highly visible and supported at all levels of the organization.

Interestingly, a doctor spoke of the importance of using "captivating language" when engaging with medical staff around translating evidence into practice. This participant felt it was important to couch the psychoeducational counseling as a "supportive conversation" with women about their fears as opposed to using "jargonistic" language that set the BELIEF framework up as an "intervention." Applying a "framework" was considered a potential barrier.

Resistance—"Fear and Self-Interest Hampers Change"

Around two thirds of survey participants ($n = 37, 67.3\%$) also considered colleagues' resistance to changing their practice as a barrier. Half of all comments identified skill deficits as a main problem, with improvements in education, ability to rotate between areas, and a supportive organizational culture considered as solutions.

Staff fears, beliefs, and attitudes were identified as main barriers to implementing midwifery-led psychoeducational counseling by interviewees and focus group participants. One interviewee noted, "Sometimes staff can find some of these things threatening. You're asking them to do something new, something that maybe they haven't done before. . . . Part of the training is about reinforcing that yes you do have these skills." This participant spoke of anticipating some apprehension and then affirming midwives' existing skills. This participant offered domestic violence as an example of an issue midwives already discuss with women, stating "midwives may think this is a difficult area to discuss but in fact they're already asking really difficult personal questions but they're used to doing them." There was a need to normalize that capacity as part of the role of the midwife.

Similarly, some clinicians questioned whether the psychoeducation was within a midwife's scope of practice, "I can actually see some staff feeling that it's actually not part of their scope of practice." Interestingly, the reverse was true of leaders who were interviewed. They clearly believed psychoeducation to be a normal part of midwifery practice. One said, "Well isn't it just what midwives do?" and another, "It shouldn't be anything different from what you're doing now." Although acknowledging the counseling was within the scope of midwifery practice, another interviewee did identify it as a potential barrier, "It's working within the scope of practice but for many midwives they will see that as an additional add-on to what they already do."

Personal beliefs were also considered to play a significant role when trying to change practice. Although the evidence might clearly demonstrate the value of a practice and/or intervention, some clinicians may not be willing to adopt it simply because it differs from their personal beliefs or experience. One clinician noted, "Someone might think 'I absolutely believe that this is the case, so I'm going to carry on doing this regardless of the evidence.'" Another example of resistance to change was provided during an interview when the participant described how some medical staff had refused to adopt recommendations from their governing body: "Apart from the fact that it was basically the RANZCOG guidelines, so it was their governing body . . . , it doesn't mean to say that they will." Another participant spoke to this issue stating that "sometimes people choose to ignore evidence because it's inconvenient." Whereas another spoke up and said, "I think probably the main barriers . . . would be some of the die-hard midwives who've done the same thing since Adam was a boy, and don't want to move into the future."

Focus group and interview participants alike articulated that the use of "local champions" was likely to be a good strategy to address and support change. Strong advocates who could "spear head" the implementation process were considered essential. As one participant said, "I would want to get some champions to actually help drive it, because if you haven't got some champions, and this is where you want to go, it's not going to get anywhere."

The Fragmented System Is a Barrier in Itself—Continuity Is the Way to Go!

One of the "other" main barriers to successful implementation of the psychoeducational counseling was the fragmented way maternity care is commonly delivered

to women. Limited access to continuity of midwifery care was identified as a significant barrier because it meant there was no relational context in which the relevant information could be disclosed in an unpressured way. In a midwifery continuity model, the disclosure of a woman's fear about birth and/or previous history of trauma was something that could evolve over time: "You don't have to discuss everything at the booking." Having more time with the woman was considered essential. Another participant compared models: "It's difficult with the GP shared care because you're not going to be seeing them [the women] again. It's easy with the continuity women because you can actually bring them back. You don't have to stick to the schedule of visits." Likewise another midwife argued that her time would be managed differently, "Obviously then because you're not going to be restricted to a half hour or an hour and a half appointment."

Organizational Support an Essential Enabler

One of the main enablers identified was organizational support for the project. This support included the physical environment, resources in the form of more staff, adequate time to provide the counseling and "also the willingness of the organization to support the midwives." As identified in the interviews, survey respondents wrote about appropriate training, follow-up support and commitment from the organization which would help build confidence. One participant identified the need for the executive leaders within the institution to commit to the project as well: "Organizational support has to come from actually above the department level . . . it has to be embraced and sold as a positive from up there in order for it then to be picked up and worked with down here."

DISCUSSION

The results presented in this article describe the first phase of a larger knowledge translation project. The practice was an evidence-based psychoeducation counseling intervention delivered by midwives and designed to decrease women's fear and increase confidence for normal birth. Organizational factors, including barriers and possible solutions that may impact on midwives being able to successfully apply the intervention in practice were explored. Although the results need to be interpreted with caution and cannot be generalized given the study was undertaken at a single site, the findings highlight the challenges of translating evidence into practice and appear to mirror the international literature on practice change within health care settings.

First, our findings clearly position the midwife as the most appropriate professional to support pregnant women experiencing fear of birth and psychosocial risk. However, few felt they had the knowledge and skills to carry out this vital task. This finding resonates with the earlier work of McLachlan, Forster, Collins, Gunn, and Hegarty (2011) who evaluated an advanced psychoeducation communication skills package for midwives. Although these authors did not measure skill level specifically, a pre–post survey identified significant improvement in their competency to address psychosocial issues, implying a skill deficit prior to the intervention.

Similarly, participants demonstrated a shared philosophy and believed in normality and positive experiences for women. This is an important finding because attitudes to birth are an important predictor of birth outcomes for women with fear of birth. For example Norwegian researchers Halvorsen, Nerum, Sørlie, and Oian (2010) found that the attitudes of counselors toward fearful women requesting cesarean section, made a significant difference to the number of women who ultimately changed their view and requested to labor and birth vaginally. Working from a position that emphasized the woman's ability to overcome any emotional obstacle to vaginal birth (called a coping attitude) was positively associated with a change in birth preference compared to one that emphasized that the ultimate choice of mode of birth was the woman's (autonomy attitude).

The impact of failing to address women's fear of birth in an effective and timely fashion can lead to suboptimal birth outcomes such as poor emotional health, increased rate of operative birth and negative birth experience (Haines et al., 2012). Acknowledging the plight of women experiencing childbirth fear prompted the United Kingdom's National Institute of Health and Care Excellence (NICE) guidelines (NICE, 2011) to recommend that women expressing fear of birth should be provided intensive midwifery support. In response to these recommendations, a recent NHS England Maternity Unit Survey was conducted to establish what specialist services were being offered for women with fear of birth (Richens, Hindley, & Lavender, 2015). Richens et al. (2015) reported more than half of units that responded provided specialist services for women experiencing fear. Almost one third of units provided midwife-led clinics (31.8%), whereas one in seven used

obstetric-led clinics. The use of psychology clinics for fear of birth was rare (4.5%).

Although our findings position the midwife as the most appropriate professional to address and manage fear of birth, there were disparities identified through the implementation evaluation process. Despite positive attitudes toward supporting women experiencing childbirth fear, there was an identified lack of knowledge, EBP skills and confidence, as well as significant organizational barriers to overcome. For example, the largest identifiable barriers were perceived to be time constraints, skill and resource deficits, organization culture, and service structure. These barriers are well-documented within the literature pertaining to barriers influencing EBP implementation (Brown, Wickline, Ecoff, & Glaser, 2009; Fairbrother et al., 2016; Gerrish & Clayton, 2004; Harding, Porter, Horne-Thompson, Donley, & Taylor, 2014; Heiwe et al., 2011; Jette et al., 2003; Koehn & Lehman, 2008; Majid et al., 2011; Solomons & Spross, 2011; Suttle et al., 2015; Umarani, 2014; Yadav & Fealy, 2012).

Similarly, our findings reinforce previous research that identified a disparity between positive attitudes toward EBP in theory and its clinical application, potentially hindering implementation (Heiwe et al., 2011). For example, although the vast majority of respondents believed EBP optimizes best clinical care, and that their own care was evidence-based, only a half believed they could search for best evidence in a timely manner, overcome barriers to EBP use, or believed they were either knowledgeable and/or confident to implement EBP. Similarly, less than a third reported being sure how to measure outcomes. These findings emulate those of others (see, e.g., Majid et al., 2011; Stokke, Olsen, Espehaug, & Nortvedt, 2014). Authors of a recent Australian study which aimed to establish behaviors and barriers in relation to EBP among senior nurses and midwives concluded that limited access to, and understanding of, research material acted as primary barriers to research use (Fairbrother et al., 2016). In addition, time related barriers were significant to the application of EBP commensurate of this study findings (Fairbrother et al., 2016).

Current organizational culture and structure were also identified as potential barriers to EBP use within the study site. Again, this finding resonates with others (Gerrish & Clayton, 2004; McCormack et al., 2002). Findings from the CLOCS subscales identified that participants scored high for Affiliation and task Accomplishment but low for Influence and Dissatisfaction. This suggests midwives were committed to quality care and strove for excellence but felt hindered in their ability to produce quality outcomes. Perceived low levels of agency around influencing workplace change may play a role here. Institutional hierarchical structures and processes may actually dictate non-EBPs that midwives feel powerless to challenge or change. In line with the work of Gerrish and Clayton (2004), our findings may be indicative of a workplace environment that may not easily be receptive to change. Some time ago, Gerrish and Clayton postulated that although consideration is often given to the importance of team culture, little attention is given to the wider organizational, management, and political influences that can impact clinical practice.

Finally, the current design of service provision at the study site was identified as a potential barrier to the implementation of midwife-delivered psychoeducation. Most participants (more than 95%) work within a standard model of maternity care that is designed around delivering "acute" hospital-based services. Within this model, midwives are afforded little opportunity to develop meaningful relationships with women. Generally, midwives provide care to large numbers of women within tight appointment schedules. Limited exposure to a known midwife and time constraints—synonymous with "routine maternity care"—were described by many participants as problematic. In contrast, continuity of care with a known midwife was identified as an enabler that would address several barriers. The benefits of continuity of care are well-known and include reduced birth intervention, increased spontaneous vaginal birth rates, and increased satisfaction compared to other models of care (Sandall, Soltani, Gates, Shennan, & Devane, 2016). The ability to work across the full scope of midwifery practice and form a meaningful longitudinal relationship with a woman across their childbirth experience (Walsh & Devane, 2012), can facilitate the implementation of psychoeducation counseling intervention for women experiencing fear of birth.

Although it is important to pinpoint the barriers to knowledge translation, it is also crucial to identify the enablers and facilitators. In this way, interventions can be customized to the health care context. One systematic review of 32 randomized controlled trials concluded that tailored implementation can be effective (Baker et al., 2015). The current organizational scan conducted in Phase 1 of our evaluation successfully identified potential barriers to the implementation of our psychoeducation counseling intervention at the study site which it seems are commensurate to barriers in many similar clinical organizations (Gray, Joy, Plath, & Webb, 2012; Grose, 2016; Veeramah, 2016). To assist

the successful implementation of our tested intervention, strategies must now be developed to manage or remove these barriers. There appears to be overwhelming agreement that addressing time-related factors are key to making practice change based on evidence (Brown et al., 2009; Fairbrother et al., 2016; Gerrish & Clayton, 2004; Harding et al., 2014; Heiwe et al., 2011; Koehn & Lehman, 2008; Majid et al., 2011; Suttle et al., 2015; Umarani, 2014; Yadav & Fealy, 2012). In addition, cultural changes are required that break down hierarchies, build teams, and empower staff, with visible supportive leadership being a vital component (Aarons & Sommerfeld, 2012; Bushe & O'Malley, 2013; Carroll & Quijada, 2004; Muls et al., 2015). Strategies must also focus on providing the education required to deliver the counseling in a way that meets the learning needs of all midwives and staff caring for women with fear of birth. Strategies aimed at embedding research and education within the workplace will also be central to ensuring EBP becomes the cultural norm (Gerrish & Clayton, 2004; McCormack et al., 2002).

CONCLUSION

This study goes some way to identifying the potential readiness, barriers, and solutions to the widespread implementation of an evidence-based psychoeducation intervention delivered by midwives for women fearful of birth. Although the study was undertaken in one site many of the identified barriers are commensurate with the international literature on translating evidence into clinical practice. The findings will inform the second phase of our research. Capacity building strategies will be needed to increase the knowledge and skills of midwives in the area of psychoeducation. Current organizational barriers related to fragmented service delivery, however, may well prove challenging to overcome.

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