Antenatal Depression: Developing an Effective and Co-ordinated Service Response

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TABLE OF CONTENTS

Executive Summary

Current national health policy has identified perinatal depression as an area of clinical priority (DoH, 2000; DoH, 2002; DoH, 2003). In addition, the Government's consultation document, *Supporting Families* (Home Office, 1998), indicated a need for strengthening the support for families at 'critical points, such as the birth of a child' (p.31). The Confidential Enquiries into Maternal Deaths (2001) highlighted the risks of mental illness in the antenatal period and recommended that there should be clear protocols and routes of referral for those caring for women who develop psychiatric problems antenatally. An exploratory study to consider how an effective and co-ordinated local service response for antenatal depression might be developed was commissioned by West Hull PCT in 2003 and conducted by staff at the University of Hull between October 2003 and April 2004. This report presents the background, methodology and results of the study which included focus groups with mothers and a survey of community midwives and health visitors in the West Hull area. The conclusions address professional attitudes, the need for professionals to establish a confiding relationship with women in the antenatal period and interprofessional communication and co-ordination in primary care. The following recommendations have been developed.

Recommendations

- Midwives' awareness of and ability to detect antenatal depression needs to be increased. The judicious introduction of a screening tool might have some impact. However, there is also a danger that the use of a screening tool could constitute a barrier to the development of a confiding relationship between the midwife and patient. Mothers participating in the focus groups described clinical procedures as impeding communication in this way. A series of social and psychological indicators, such as that developed at Glasgow's Gartnaval Hospital might prove more useful in this respect. Locally, Sure Start have piloted an initiative in the Marfleet area of Hull using a questionnaire which also offers some possible indicators.

- Training needs to be delivered to all those staff involved in antenatal care to develop knowledge of antenatal depression, referral routes and relevant local services. In some areas, such training has already been introduced. Training should be interprofessional and should include GPs who play a key role in diagnosis and in securing access to mental health services.

- Midwives need to have the capacity to negotiate their caseloads in order to be able to spend additional time with women who may be at risk of or experiencing antenatal depression. This flexibility is currently available to Sure Start staff but not to those employed in mainstream services. The benefits of this model need to be transferred across to NHS practitioners.

- In the long term, the work of midwives and health visitors could be more effectively co-ordinated by bringing them together in integrated community-based teams. The introduction of extended schools may offer opportunities for such developments.

- Locating specialist mother and baby community psychiatric nurses (CPNs) with community health workers would offer a means of developing an effective response to antenatal depression. Such a structure would spread expertise, promote the confidence of community health workers in this field and provide a link between community health and mental health services. The study did not include hospital midwives but they also need to have access to mental health expertise and awareness.

- West Hull PCT needs to work with community mental health services to define the criteria used to access services for both expectant mothers and those with young children. A focus on high risk and 'severe and enduring' mental illness has the effect of excluding from services many women whose mental health needs are conceptualised as 'reactive'. The perinatal period is the period when women are most at risk of developing mental health problems and the long-term impact on them and their children may be considerable. Mental health services and PCTs need to undertake joint planning to ensure that mothers have access to relevant services in the antenatal period.

1. Introduction

This report presents the findings of a study undertaken in 2003 - 2004 by staff from the department of Nursing, Social Work and Applied Health Studies at the University of Hull. The research was funded by the West Hull Primary Care Trust.

1.1 Background to the Research

Increasingly, attention is shifting away from a focus on postnatal depression in women to a recognition that depression may be an on-going or recurrent experience in many women's lives, with pregnancy and the parenting of young children constituting periods of particular vulnerability. It is thought that antenatal depression occurs in approximately 10 per cent of women (Cox and Holden, 1994), although some studies put this figure as high as 17 per cent (Josefsson *et al*, 2001). Research studies carried out in inner-city populations both in America and Britain have found prevalence rates of 25 per cent or more (Hobfoll *et al*, 1995; Bolton *et al*, 1998). Evans *et al* (2001) found that depressive symptoms were significantly more prevalent at 32 weeks gestation than at eight weeks postpartum and this trend is also highlighted by other authors (Green and Murray, 1994; Levy and Kline, 1994; Hayes *et al*, 2001). Certain risk factors have been documented as being related to the occurrence of antenatal depression, including lack of a cohabiting partner (Hobfoll *et al*, 1995); marital disharmony (Johanson *et al*, 2000); unemployment and lack of qualifications (Bolton *et al*, 1998); previous depression (Spinelli, 1997) and unplanned/ unwanted pregnancy (Rubertsson *et al*, 2003). Studies which have looked at the effects of depression during pregnancy have identified a range of possible outcomes including the intrauterine environment being adversely affected (Tcixeira *et al*, 1999); the quality of maternal care being altered (Green and Murray, 1994) and offspring possibly being at greater risk of behavioural problems as children (O'Connor *et al*, 2002) or criminality in later life (Maki *et al*, 2003). However, these areas of research require further investigation and possible replication in order to add validity to the findings.

The NHS Plan (Department of Health, 2000) has identified mental health services for women as an area of clinical priority and the government's consultation document on the strategic development of mental health services for women (Department of Health, 2002) advocates the development of local specialist perinatal mental health services. The implementation guidance for this strategy (Department of Health, 2003) emphasises the need for early detection of mental health problems both antenatally and postnatally and cites the key role of midwives and health visitors in the detection and management of perinatal depression. In addition, the Government's consultation document, *'Supporting Families'* (Home Office, 1998), indicated a need for strengthening the support for families at 'critical points, such as the birth of a child' (p.31). The Confidential Enquiries into Maternal Deaths (2001) highlighted the risks of mental illness in the antenatal period and the report recommended the development of clear protocols and routes of referral for those caring for women who develop psychiatric problems antenatally.

In a recent survey of 182 maternity units in England and Wales, Tully *et al* (2002) reported that only 36 per cent of the units had policies relating to the management of women suffering from psychological distress during the antenatal period. Pregnancy involves a significant amount of contact with health services and provides an opportunity for depression to be identified at an early stage and preventative services to be delivered (Clark, 2000). The findings reported by Tully and colleagues (2002), however, highlight that screening for depressive symptoms very often does not take place at all during pregnancy. In addition, it is unclear from the literature which health professionals, i.e. midwife, health visitor or GP, are best placed to detect psychological vulnerability and how women can be supported effectively when depression is identified. There is some evidence that in certain areas health professionals are attempting to address the issue of depression in the perinatal period by initiating programmes which involve early detection and intervention (Bolton *et al*, 2001; Allen *et al,* 2002; Robertson, 2004), but these are local initiatives and there are no national guidelines relating to screening and treatment for depression occurring in the antenatal period.

There is considerable debate around screening for depression both during pregnancy and postnatally (e.g. Adams, 2002; Leverton and

Elliot, 2000; Austin and Lumley, 2003) and generally, the use of standardised assessment tools is proliferating in health and social care. The Edinburgh Postnatal Depression Scale, developed in the 1980s (Cox *et al*, 1987) is probably the most widely used screening tool for perinatal depression and has been validated for use in the antenatal period (Murray and Cox, 1990). The National Screening Committee (NSC) has not, however, recommended its use nationally in routine screening for postnatal depression (Adams, 2002), and its use in an antenatal context has not been discussed (see website at www.nelh.nhs.uk/screening). The NICE guideline *'Antenatal Care – Routine care for the healthy pregnant woman'* specifically advises against the use of routine antenatal screening for perinatal depression as its efficacy has not been established (NICE, 2003). Concerns have been expressed about the danger of screening or assessment tools becoming an end in themselves (Stanley, 1999; Horwath, 2002) and about scales being administered incorrectly or without a clear course of action being identified for the health professional to follow if possible depression is identified (Elliot, 1994; Cox and Holden, 2003). Some authors suggest that one of the main benefits of formal screening could be the ability to legitimately focus on the woman's emotional state, thus giving her the opportunity to express her feelings openly (Clark, 2000). Given these differing perspectives, it is important to explore how best to detect and treat antenatal depression in the light of the NICE framework.

Stewart and Henshaw (2002) identify midwives as key professionals in predicting those at risk of perinatal mental illness and Tully *et al* (2002) highlight the central role of the midwife in referring women on to appropriate services in the antenatal period. However, midwives' knowledge of appropriate referral routes may vary. Tully *et al* found that midwives regularly communicated with health visitors concerning depression in women, but the nature of such communication was unclear and the use made of such information needs to be researched. The consultation paper on women's mental health (Department of Health, 2002) suggests that care pathways may provide a model for co-ordinating perinatal mental health services. In some areas, integrated care pathways are already being developed for use in the perinatal period (Cantwell, 2003).

1.2 Research Objectives

These were established in consultation with the research commissioners and included the following:

- To explore mothers' levels of awareness of antenatal depression and identify what services and forms of support appear most accessible to them.
- To identify the level of community midwives' and health visitors' knowledge of depression during pregnancy and to discover if screening currently takes place.
- To establish the range of referral routes and support services which community midwives in West Hull access for mothers with depression.
- To discover the degree of communication between midwifery and health visiting services in West Hull with regard to pregnant women's mental health needs.

1.3 Methodology

The project was approved by the local NHS Research Ethics Committee, and an advisory group which included local health professionals and a user representative was convened to provide guidance and consultation on the design and execution of the research.

The project consisted of two main stages:

Stage 1 – Four focus groups took place with mothers whose youngest child was under the age of two. These were held in a variety of settings in the West Hull area and participants were accessed through local Sure Start projects, clinics and the National Childbirth Trust. Groups that were already in existence were used in order to benefit from the mothers' familiarity with one another. The group discussions were taped and transcribed with the participants' permission and the anonymity of all those who took part in the study has been protected. The data from these groups were analysed thematically and findings were used to inform the design of the survey.

Stage 2 – A postal questionnaire was sent to all community midwives and health visitors working within the West Hull Primary Care Trust area (n=47), covering knowledge of depression in the antenatal period, use of screening, routes of referral and resources needed for better detection and treatment of

antenatal depression. The questionnaire was piloted on midwives and health visitors and potential problems were rectified. Thirty-nine questionnaires were completed (a response rate of 83%) and the data were analysed using SPSS.

2. Mothers' Views

2.1 The Sample

The four focus groups of mothers constituted a convenience sample and were accessed through contact with health visitors, Sure Start workers and local National Childbirth Trust (NCT) contact mothers. Two focus groups took place at Sure Start facilities, one in a multi-purpose health centre and one in an NCT member's home. The numbers in the focus groups ranged from three to ten. All the women in the groups had at least one child under the age of two. In total, 28 women participated in the focus groups. It was anticipated that women who already had children (rather than those who were pregnant) would be able to comment on pregnancy from a 'middle distance' without feeling pressured to disclose current problems or difficulties.

The themes arising from the focus groups fall broadly into four main categories which are discussed in turn below: Experiences of Pregnancy; Experience of Health Professionals; Informal Support Networks during Pregnancy and Barriers to Seeking Help. In the text that follows, quotations from focus group members are in italics, whilst the facilitators' questions appear in plain text.

2.2 Experiences of Pregnancy

Inevitably, there was a wide range of experiences relating to emotions in pregnancy, ranging from the very negative:

> *I hated it.* (FG1)

To the very positive:

> *Very happy, actually*. (FG3)

> *... my pregnancies, both times, I felt best, the most healthy, most ... alive that I felt.* (FG2)

Many women highlighted the mixture of emotions that accompany pregnancy and the way women's feelings can swing from one extreme to another:

> *. . . it was a combination of excited and scared.* (FG2)

> *One minute you feel fine, the next minute you can just burst out crying for no reason.* (FG3)

> *Yes, excited about it, quite excited but frightened of it, certainly frightened.* (FG4)

Discussion surrounding the nature of normal emotions in pregnancy revealed that some women were unprepared for the 'rollercoaster' (FG2) of emotions that women can experience antenatally:

> *And especially if it's your first, you go through a little wave of different feelings and emotions and you don't know what's right and what's wrong and there's no, that's not to say that anything you feel is right or wrong really, it's just because it's new to you, it's just different.* (FG4)

There was an acknowledgement that a range of feelings could be considered normal in this period, but that unusual emotions might be mistaken for common ones because the woman has nothing to compare them with:

> *I think everybody's different, aren't they? Everybody goes through different things.* (FG1)

> *Yeah, there is no one way to feel.* (FG2)

> *I didn't realise, which I suppose makes it worse, you don't realise what's happening, and I just naturally assumed, because it was my first, I naturally assumed that is how all pregnant women felt, it wasn't until after she was born and I talked it through with a midwife at Hull Royal, she was lovely, she said it sounds like you've been depressed and why didn't anybody pick it up?* (FG1)

The need for the pregnant woman to come to terms with the transformation of her identity emerged as a key issue within the groups. This theme encompassed the physical adjustments that had to be made, but the focus group participants also noted changes in other

people's responses to them when they became pregnant:

> *I felt I wanted to do everything and the bump was physically stopping me, I got very frustrated from that point of view, that I couldn't do things physically that I could do before ...* (FG2)

> *... I think other people's attitudes change towards you.* (FG1)

> *... people feel free to comment, as if you're public property because that bump is there to be talked about, right to your face.* (FG2)

> *I was surprised how many people felt they could sort of come up, complete strangers ... touch your tummy.* (FG4)

Some women commented on how the transformation was not confined to changes in pregnancy but also signalled the first stage in the shift to assuming the role of mother:

> *Well it just doesn't change you physically, it changes everything, changes your whole life and changes your family life as well, it sort of, the next stage of, because you become a mother then, and you know reversal, 'cos you're not the child anymore you're the mother ...* (FG2)

Looking forward to their future role as mothers was identified as a source of anxiety for a number of the women:

> *I thought I'd be the world's worst mum, you know get everything wrong.* (FG1)

> *I'm not going to cope and you know I'm having a baby girl and I've got two boys and I haven't got a clue, you know, not thinking I was going to cope at all, not at all, yeah I was, you know crying all the time, thinking I'm making a big mistake here.* (FG3)

Certain vulnerability factors were identified by the women as having the potential to lead to emotional problems and possibly depression in pregnancy. It was felt that various aspects of a woman's social and personal circumstances might cause difficulties in coping with the pregnancy, particularly if the pregnancy was unplanned:

> *When I got pregnant first time, it was quite unexpected ... and it was really the wrong time to be having a baby and I just, I felt quite devastated when I got pregnant first time, and I felt like that, just cried and cried, the whole time, there was no excitement first time round, like.* (FG2)

> *I think if you never meant to get pregnant, it is a huge thing to have, have a baby and to not want to be, I think it must be awful, 'cos you're not, you know it's either an abortion or an adoption or whatever, it's, you know, and as much as you say, well you shouldn't have got pregnant in the first place, it's, we've all, you know I sort of think, oh crikey.* (FG3)

Some of the focus group participants identified themselves as having experienced depression antenatally and they described some of their feelings:

> *Isolated, lonely, with the baby it was a lot worse, I was ... suicide I think with her, I got that bad.*
>
> Was that towards the end then?
>
> *Oh yeah, that was probably, about three weeks before I was due to have her and it just gradually got worse. In the end I couldn't be left alone, not with her, everybody was, everybody feared for my safety.* (FG1)
>
> *No enthusiasm for anything as well.* (FG1)
>
> *I kept most of it just bottled up, I didn't really speak to anyone, just talked to that cat.* (FG1)

Other women described how they thought depression might manifest itself in pregnancy:

> *With any form of depression, the very nature of having the depression would sort of, you don't talk about it do you? I mean that's part of the problem really. The inward thinking rather then the outward thinking ... I've lived with a person who, who was depressed and yes it's, she'd never sort of say I, you know I am depressed and I feel, she'd talk to me 'cos I was very close to her but she wouldn't talk to other people ... she used to go to bed a*

lot and sort of not go out and stay at home a lot and you know. (FG2)

Just crying all the time and can't be bothered with theirselves I think, it's like a depression isn't it? (FG3)

The groups were asked if they felt that there were any differences between the first pregnancy and the second or subsequent pregnancies. There was a general sense that pregnancy was easier to adapt to the second time around because women knew what to expect:

I think when you've already been through it, you're certainly more calm about the situation, you know what's going to happen, you know all the different stages of pregnancy and you understand more about what's going on, and you're just less anxious. (FG4)

However, the focus group participants also expressed the feeling that women were left to their own devices more in later pregnancies and were less able to focus on the pregnancy:

Just think [you] get on with it more on the second pregnancy. (FG2)

You know it's not, I don't think, I don't always think your second pregnancy's as special as your first. (FG3)

Some women commented on how they had felt at a disadvantage when comparing their own feelings with their perceptions of other pregnant women. There had felt a need to match up to the way other women behaved:

... and they all seemed to breeze through it, you know I've watched them and they all seemed, you know just taking everything in their stride. (FG1)

See other people do what you think you've got to ... you've got to cope. (FG3)

2.3 Women's Experiences of Professionals

Focus group members described a range of experiences of health professionals and their care during the antenatal period. Many women commented on professionals' insensitive attitudes towards them, particularly when they were trying to communicate problems or negative feelings:

... and I did mention something and my doctors were actually no use, they just turn around and said 'oh well it's the weather' ... (FG1)

... you're new to all this and they've got their knowledge base that you're sort of under ... if you don't feel sort of text book, then you're different and I think that sometimes they make you feel a little bit like that really, not in a way that they realise but I think you know if you say something and somebody answers you in a way that you think, 'God shouldn't I have said that?' I think sometimes that can put you off sort of developing the relationship with ... (FG4)

...I think GPs sometimes are a little bit flippant and make you feel a little bit like you're, 'cos you're sort of asked things about how you're feeling and it's maybe silly to them but it's not to you (FG4)

The women emphasised that continuity of care and the chance to establish a relationship with those looking after them during pregnancy were key requisites if problems or feelings were to be disclosed. This was a significant theme for many women:

I think you should ... know a midwife from start to finish. (FG3)

... I saw her all through the pregnancy so I was quite lucky to be able to talk to her you see. (FG3)

Well, obviously it would be better right the way through if you did sort of make friends with your midwife, that's the model isn't it? (FG2)

But you'd have felt you'd have been able to say something to one of them?

I would personally, I would have been able to.

Because there were only two or three of them?

Yeah, it's quite a, a small group of them, so I would have. (FG2)

I used to talk to [ ] all the time, every time I had a problem I used to just go and sit in the quiet room and talk to her (FG1)

So did you feel that because you got to know her you could have talked to her?

Yeah, yeah, I mean 'cos afterwards I didn't feel like I'd bonded with him ... and I didn't like him sometimes ... I said 'is it alright not to like him?' She said, 'God yeah, you know,' and I knew I could say that to her but if it had been somebody I'd not sort of had a relationship with, I wouldn't have been able to say that, and then I would have felt distraught, I think ... (FG4)

A number of women also identified the value of being given space and time to talk about their feelings with those looking after them antenatally whilst others described the negative consequences of not having this time. The emphasis on checks and procedures in clinical settings was often experienced as a barrier to being able to communicate freely with professionals:

And even though there's a big queue outside, you never felt like they was rushing you through your little session with them, or I never did anyway. (FG4)

You need somebody to talk to ... somebody to, just to listen. (FG2)

... nobody said to me is there anything you want to talk about? (FG3)

[ ] did for me, I was in there I think an hour and a half one time, getting on for an hour anyway. (FG1)

If I had been depressed, I wouldn't have actually known who to turn to, because my midwife was so busy, it was in and out, blood pressure, she certainly never raised ... Exactly, you're just on the conveyor belt. (FG2)

... and me antenatal appointments, it was at the doctor's, and it was a case of stand on the scales, check your blood pressure, dip your stick in your, and you're out. (FG3)

Many of the women had previously been unaware of the possibility of becoming depressed antenatally and felt as if they had not been told enough about the less 'rosy' aspects of pregnancy. They felt there was a need for more realistic information and an acknowledgement that negative feelings are acceptable:

I've never even heard of antenatal depression ... (FG2)

... if everyone knows it's [antenatal depression] allowed to exist then it's going to be alright to talk about it. (FG2)

I think it's more acceptable to feel depressed afterwards ... 'cos you know that they're going to ask you about that at your check anyway and you can sort of be a bit more honest. (FG4)

More preparing and realism, straight talk, that's what ... I'd rather let them know anything they want to know rather then pretending, I think that'll help them, that'll help them the most. (FG2)

It was also felt by some that information was not given out early enough:

When I was first pregnant I wanted to read up about it all so I sort of asked, when, I think a midwife, and said right where can I go and get a book, and she said I can't suggest books, we give you a book ... your first scan, and I thought well that's quite late, I want to know things before that so I said, 'well is there any chance that I could get one?', and she said, 'well come down here ... I'll give you one'. Most other people got them at their first booking in and everything at the hospital, at twelve weeks is it? I didn't want to wait that long. (FG4)

Some women had been unaware of what to expect from services:

I suppose being a little bit naïve as well, I always thought you know when you was pregnant you would have your own midwife that sort of saw you through all your pregnancy. (FG4)

Yeah, you do have a choice, yeah. But I just always thought you went to your doctors. (FG4)

According to the focus group participants, the content of antenatal classes left something to be desired, but they were appreciated for the opportunities they offered to meet others who were pregnant and make friends:

I thought they were absolutely useless. (FG4)

We've ended up a really good group. (FG4)

Many comments were made about the general content of care received antenatally, with some women emphasising the emotional support they received and the opportunities available to disclose problems:

They made me feel, they made me realise I wasn't on my own, that, all stuff that could be done ... (FG1)

... all my antenatal care was by my GP, so I had a really good relationship with him, I felt like I could have brought that up ... (FG2)

... so then I felt that I could then speak to the midwives and the health visitor and after a few days it went anyway, but, as long as you've got somebody to talk to, that, who you can get it out in the open with and then, then you realise then don't you that other people have said well actually I felt like that as well. (FG2)

Others, however, felt that they were sometimes given conflicting advice or were not taken seriously:

... and one midwife would tell you one thing - to rest - and then the midwife said, 'that's rubbish', you know getting a bit confused. You know, sort of like, when you get two different midwives, it's a bit of conflict isn't it really? (FG3)

I actually stopped going to my GP for my antenatal check-ups. I started going to the midwives ... 'cos I, I mean I don't, I don't like one of my GPs anyway, but when I went for my first antenatal check-up ... I said, 'oh I've come for my four weekly check-up'. 'When was the baby born?' I said, 'well I'm pregnant now', and she looked at me as if I was stupid, and I thought, you know, why didn't you read the notes before I came into your office and she just wasn't interested ... (FG4)

Between them, the women had experienced a range of different types of antenatal care, with some mainly seeing their GP and others seeing a midwife, either at a health centre or at a Sure Start facility. Those who attended Sure Start generally appeared to be satisfied with their pattern of care, but others were not always positive. Sure Start staff are of course more likely to have a limited caseload and the time available to offer women opportunities to form a relationship and disclose problems:

If you haven't got the right staff you don't have the atmosphere that's here. (FG1)

Nobody discussed pain relief with me, nobody discussed anything with me, I could have asked, don't get me wrong, that was probably my fault for not bringing it up. (FG3)

Didn't have a midwife that, as I say I didn't really see a midwife, or certainly nobody that I would have spoken to. (FG3)

Focus group participants were asked who they might talk to if they felt they had emotional problems. Many made it clear that they would not be able to discuss their feelings with their GP, although some did indicate that they would consider going to their doctor in the first instance:

So you wouldn't go to your doctor first?

Got more chance of seeing diamonds drop from the sky than them helping you. (FG1)

At that point would you go to your GP?

Personally I don't know, I don't know what I would have done to be honest ... 'cos I say I wouldn't have spoken to my GP. (FG3)

I'd talk to my doctor first ... about it and see what he has to say on it. (FG3)

2.4 Informal Support Networks

There was some discussion in the focus groups concerning the role of family and friends during pregnancy and the ways in which support was offered by these groups. The majority of comments were positive and reinforced the vital role that those nearest to the women played, but some felt that their friends and relations were not always able to see things from the expectant woman's viewpoint:

> *I think people just get concerned for you, I think sometimes it can be too much for you being pregnant to being too fussy and all the rest of it, but ... they care, I think a lot of the time.* (FG1)

> *And when I actually expressed my feelings to [friends], oh don't worry about it.* (FG1)

The women in particular talked about their own mothers and how their relationship with them was affected:

> *I did get quite depressed with the first baby, and I got my Mum straight away, Mum came down and talked it through with her and discovered that she felt the same ...* (FG2)

> *... I mean probably more my mum then anybody else, I think because you know it is your mum and she's been there and you know.* (FG3)

> *... they'd think you was evil ... That's what my mam thought of me 'cos I kept saying I didn't want him, I wanted to get rid of him, so.* (FG1)

A number of the women stressed the fact that they would be more likely to seek help from family, partner or friends before turning to a health professional:

> *No, because when you have those feelings you tend turn to people that are closest to you, whether it's a friend or a family member don't you?* (FG2)

> *... I think I would probably start speaking to my husband or my mum, or a close friend or, before I went to anyone professional ...* (FG4)

Groups of friends who supported each other through pregnancy were also seen as a valuable source of help:

> *Fortunately when I was pregnant quite a lot of my friends were, just the way things worked out, so it was lovely to be going through things with other people, to be able to compare notes. I think if I had been doing it on my own and not really had anybody close to me, I think I'd have been a bit, a bit frightened ...* (FG4)

> *... the NCT ones are usually in someone's home, and you feel more private, you're able to talk more as a group of friends if you go every week.* (FG2)

Some women also saw the need for specific support groups during pregnancy to give expectant women the chance to talk and make friends, especially if they were having emotional problems:

> Who do you think they should go to, who would be the best person to talk to?

> *Somebody that is actually in there, in it. You know got through it ... I suppose.*

> Some sort of proper support associations?

> *Yeah, something, yeah. I kept saying about my pregnancy with him, you know somebody somewhere has got to be able to help.* (FG1)

2.5 Barriers to Seeking Help

A major theme to emerge from the focus groups concerned those obstacles which might prevent a pregnant woman who was experiencing emotional difficulties asking for help. Increased awareness concerning which feelings in pregnancy fall within the normal range and which are beyond it might help women to identify a need for professional help:

> What do you think stopped you telling people how you felt?

> '*Cos I actually thought that was how everybody felt, it was, it was the fact that I thought that's how everybody felt.* (FG1)

As noted earlier, many women were unaware that depression could occur in the antenatal

period and it was felt that this lack of awareness could act as a barrier to seeking help:

> *But that there's nothing sort of documented about you being depressed while you're pregnant, I don't think that's, not a good thing really*. (FG4)

A number of the mothers identified shame about not being happy and 'blooming' as an obstacle to sharing their feelings:

> Do you think there's anything … that might stop you asking for help?
>
> *Being ashamed*. (FG1)
>
> *... you know if you're feeling a failure and everything, I don't think I would have talked about that with anybody ...* (FG3)
>
> *I think if I had any of those feelings, I wouldn't have told anybody, I would have kept them to myself.* Why not? *Because they would, they're not normal feelings and it's not how you're supposed to feel when you're pregnant.* (FG4)

Many women cited the attitudes of health professionals as a potential barrier to asking for help with emotional difficulties:

> *... but I think some health professionals can make you feel guilty about the way you're feeling as well, I think, and I don't think they mean to do that, but ...* (FG4)
>
> *My doctors, my doctors are useless, they've got a very good habit of making you feel about an inch tall, really good habit of doing that.* (FG1)

Some women were also worried about the consequences of telling a health professional that they were depressed and having negative feelings. In addition to the stigma or shame which might result from the disclosure of problems, an underlying fear of having a child removed through state intervention was evident:

> *In case somebody had a go at you for [it]*. (FG1)

Do you think it's easy though, to express those sorts of things?

> *No, 'cos you're meant to be happy about ...I mean you wouldn't go and voluntarily tell a health visitor that would you?*
> No [laughter] ...
>
> *Child Support Agency.* (FG2)
>
> *... I think towards the end if you were to say you were depressed, you couldn't say because, if you told that to a midwife you just don't know what they might do.* (FG4)

The data gathered from the focus groups highlights the range of emotions and experiences that women encountered in pregnancy and the need for these to be normalised. However, women would also have benefited from increased awareness concerning the possibility of depression and knowledge of what feelings might constitute deviations from the norm. Women want to know what to expect and they want to be able to access the resources to deal with these situations effectively. It is evident that pregnant women have expectations of the care they should receive during the antenatal period, particularly surrounding the availability of professionals whom they can develop a relationship with and who can give them the time and opportunities they need to talk about how they really feel. Earle (2000) highlights the importance of continuity and the building up of relationships between midwives and pregnant women in order to:

> *'foster both a sense of similarity to others and a sense of personal uniqueness, which appear essential to the maintenance of self-identity during pregnancy.'* (p.235)

This is particularly important if negative feelings, perceived as unacceptable in pregnancy, are to be disclosed. There was a range of experiences concerning the standards of antenatal care, but most women were happy if they were treated seriously, as an individual and with respect. It was acknowledged that families and friends have a role to play in support during pregnancy and in helping the woman to make the transition to being a mother or increasing the size of her family. However, this was seen as complementary, but distinct from the role of health professionals. The problems women might have in discussing their feelings with health professionals during pregnancy need to be addressed, and ways of

dismantling these barriers should be explored. One such approach would involve incorporating certain characteristics of the Sure Start model into mainstream services. Key elements of the model include: non-medicalised settings; informal access; increased time and availability of staff and positive attitudes towards women, regardless of their personal and social circumstances.

3. The Professionals and their Practice

3.1 The Sample

A postal questionnaire was sent out in December 2003 to all community midwives and health visitors working in the West Hull Primary Care Trust area (n=47). The 47 consisted of 15 midwives, 30 health visitors and two health practitioners. The final response rate was 83 per cent (n=39). Table 3.1 describes the respondent group.

Table 3.1 Summary of Respondents

	No.	%
Health Visitors	24	62%
Midwives	14	36%
Health Practitioners	1	2%
Total	39	100%

For the purposes of analysis, the health practitioner's responses have been considered together with those of the health visitors. Table 3.2 indicates the location identified by respondents as their main workbase. Over a quarter (n=10) were located in Sure Start facilities, which included half (n=7) of the midwives surveyed.

Table 3.2 Location of Respondents

	Health Centre/Clinic	Sure Start
Health Visitors*	21 (54%)	3 (8%)
Midwives	7 (18%)	7 (18%)
Total	28 (72%)	10 (26%)

*One health visitor did not answer this question

All of the respondents (except one who did not specify) worked as practitioners rather than managers, and all but two were female (one did not specify). Table 3.3 shows the length of time the professionals had worked in their particular field and highlights the fact that nearly half (n=19) had considerable experience, having worked for more than five years in their current area.

Table 3.3 Length of Time in Current Field of Work

	No.	%
More than 5 years	19	49%
2-5 years	11	28%
Under 2 years	9	23%
Total	39	100%

The respondents were asked how many women they had worked with in the last two years whom they considered were depressed during pregnancy. Table 3.4 shows the responses to this question.

Table 3.4 Numbers of women worked with in last two years with antenatal depression

	No. of respondents	% of respondents
None	3	8%
1-10	22	56%
More than 10	7	18%
Don't know/ no response	7	18%
Total	39	100%

As the table indicates, nearly 75 per cent (n=29) of the respondents considered that they had looked after at least one woman they believed to be suffering from antenatal depression in the past two years. This included twelve out of the fourteen midwives. Over 40 per cent (n=16) indicated that they had worked with six or more women who were depressed in pregnancy in the past two years and more than half (n=6) of those working in Sure Start facilities felt they had been involved in the care of at least ten women with antenatal depression. The respondents can therefore be described as an experienced group of practitioners with considerable experience of encountering antenatal depression. Sure Start staff were well represented in the sample.

3.2 Who Provides Antenatal Care?

The survey aimed to discover which professionals were providing most antenatal care in West Hull and whether there was any continuity of care or carer within the current system. More than 75 per cent (n=30) of respondents (including all the midwives) indicated that the community midwife was usually the lead professional for antenatal care. Four health visitors considered that the GP took the lead in providing antenatal care in their settings. The frequency of antenatal contacts reported appeared to support the view that the community midwife plays a key role in the delivery of antenatal care. Of the 14 midwives, all but two reported that they saw women three or more times during pregnancy, although one midwife commented that obstetrically 'high risk' women were usually seen at a consultant clinic. If these women also have mental health problems, there is a potential for their psychological care to be overlooked. Sure Start service users may be seen frequently on an informal basis in the antenatal period by midwives. One midwife working at Sure Start commented that she saws women:

> *Not for antenatal 'check-ups' – for education + support + advice.*

Seventeen of the 25 health visitors only saw women once during pregnancy, with five never seeing a woman antenatally at all. A number of health visitors commented, however, that they would see women more often if there was a perceived need identified either by the woman herself or by the health visitor. Some also stated that they would see pregnant women more often if their workload permitted it. Two health visitors indicated that they saw women more than four times antenatally, both giving the reason that they worked alongside a GP during antenatal clinics.

Table 3.5 shows that the continuity of care which the mothers participating in the focus groups valued (see Chapter 2 of this report) was not consistently available.

Table 3.5 How often is all of a woman's antenatal care given by just one midwife?

	No. of Respondents	% of Respondents
Never	3	8%
Rarely	19	48%
Sometimes	10	26%
Often	3	8%
Don't know	4	10%
Total	39	100%

Fifty-six per cent of those surveyed (n=22) believed that a woman is rarely or never looked after by just one midwife antenatally, with nine out of the 14 midwives falling into this category. Five of these midwives, however, qualified this response by indicating that they worked in team practices, where the woman might be seen by any one of a small team of midwives – usually four or five. One midwife wrote:

> *There are four midwives in our team so most of the women will see at least three midwives, but as it is a small team we do manage to build good relationships with the women.*

Five of the ten professionals based in Sure Start facilities also indicated that women were rarely or never given all their antenatal care by one midwife, although one health visitor believed that Sure Start midwives were more likely to see women '*more times rather than rarely'*.

Respondents were asked to indicate the health professional whom they considered best equipped to identify depression in the antenatal period. This question produced a range of replies, but nearly 75 per cent (n=27) named the midwife as the most suitable health professional to undertake this function. Eleven of those who nominated the midwife for this role also saw the GP or the health visitor taking on this function. Six respondents thought that the '*main care giver*' was the person most likely to notice depression antenatally. If, as the respondents reported, the community midwife is likely to be the professional lead for antenatal care, then the main care giver will usually be the midwife.

3.3 Professionals' Awareness of Antenatal Depression

The respondents were asked to rate a series of statements conveying mothers' experiences during pregnancy by indicating whether the feelings expressed were normal or unusual in the antenatal period. The content of the statements (see Appendix 1) was informed by data gathered from the focus group interviews in conjunction with literature focussing on women's experiences of perinatal depression.

Varying degrees of awareness were found concerning what constitutes normal or abnormal feelings during pregnancy. Only two health professionals identified all the statements in line with the researchers' definitions, but 43 per cent (n=15) of those who responded recognised those statements designed to convey abnormal feelings. It is interesting to note that a greater proportion of health visitors were in this group (11 of the 22 who responded), than midwives (four of the 12 who responded). Health visitors, it could be argued, are more familiar with identifying the signs of depression due to the emphasis placed on screening for postnatal depression – a role that has been enthusiastically adopted by this group of professionals. There was a recognition, however, that knowledge in this area could be improved, as 31 per cent of respondents (n=12) felt that better training and education were required in order for health professionals to effectively detect and treat depression antenatally. This lack of training appears to be fairly universal as, according to Tully *et al*'s (2002) research into the role of midwives in depression screening, only 16 per cent of maternity units provided training for midwives with regard to the detection of depression in the perinatal period. However, as noted earlier, although some of the health professionals in the current survey lacked knowledge and awareness of the manifestations of depression occurring during pregnancy, many were nevertheless confident enough in their ability to discern symptoms of depression to state that they had looked after at least one women suffering from depression during the antenatal period.

Respondents were asked if they considered there was a link between depression during pregnancy and postnatal depression. Eighty-seven per cent of participants (n=34) indicated that they believed there was a relationship between the two, with 59 per cent (n=20) of these citing experience or observation as evidence for this association. Only seven respondents gave research findings as evidence for a link between antenatal and postnatal depression. As research findings to date are somewhat equivocal on a provable link between depression in the antenatal and postnatal periods (Murray and Cox, 1990; Clark, 2000; Green and Murray, 1994; Evans *et al*, 2001), this may be an area in which health visitors and midwives need an increased knowledge base.

3.4 Screening

Respondents were asked about their awareness of screening for antenatal depression and their current practice in this area. More that 80 per cent (n=34) of those responding were aware of the Edinburgh Postnatal Depression Scale (EPDS) as a screening tool which could be used to detect antenatal depression, but less than 20 per cent (n=7) knew about the use of integrated care pathways for the detection of depression antenatally. Five of these seven worked in Sure Start settings. All but two respondents indicated that they would use face-to-face contact with a woman to identify depression antenatally (n=37) – this number included all the midwives.

Again, it is worth noting the potential discrepancy between some health professionals' acknowledgement of their limited knowledge base and their perception of their own ability to detect depression in pregnant women. Less than 50 per cent of all respondents indicated that they would use a specific screening tool either at pregnancy booking (n=13) or later in the antenatal period to detect depression (n=18). The data suggest that the midwives surveyed were no more likely to use a screening tool in pregnancy than the health visitors. However, over 60 per cent (n=25) of respondents felt that they would be likely to identify antenatal depression through referral from another professional. Four midwives indicated that they used the EPDS currently in their practice (sometimes in conjunction with specific questioning) during the antenatal period, but these midwives were all employed in Sure Start settings. Seven health visitors also used the EPDS antenatally, most of these practitioners were based in clinics or health centres. Seven of the 14 midwives did not use any form of screening for

depression in the antenatal period, nor did 15 of the 25 health visitors. However, as seen above, few of the health visitors saw women more than once antenatally.

Respondents were asked if they routinely discussed any social or emotional factors with women during pregnancy. A wide range of answers was received (see Table 3.6 below), with nearly 50 per cent (n=19) exploring three or more factors with women antenatally. However, four of the midwives and six of the health visitors did not list any factors.

Table 3.6 Social and Emotional Factors discussed antenatally

Factor listed	No. of times mentioned
Family/partner support	25
Housing	16
Financial situation	13
Planned pregnancy/happy	10
Current emotional state	9
Expectations of parenthood	9
Domestic violence	8
Employment	8
Mental health history	7
Social services involvement	3
Other children	3
Drug use	2

Of those areas of discussion listed, family or partner support was the issue most likely to be raised, 26 per cent (n=10) explored whether the current pregnancy was planned or if the woman was happy about being pregnant and 23 per cent (n=9) asked about the pregnant woman's current emotional state. The data from the focus groups highlighted the importance for women of whether a pregnancy was planned or not and how the woman herself felt about it. There is perhaps a need to consider whether routine questioning in these areas should be more widespread. Only 20 per cent (n=8) addressed the possibility of domestic violence: an issue highlighted as significant by The Confidential Enquiries into Maternal Deaths (2001) which found an increased risk of suicide in the perinatal period in situations where domestic violence was a feature. The Confidential Enquiries also emphasised the need to record an accurate mental health history in the antenatal period in order that previous experience of depression or psychosis can be integrated into a woman's plan of care. As can be seen from Table 3.6, less that 20 per cent (n=7) of health professionals indicated that they asked about a woman's mental health history antenatally. This is an issue that needs to be addressed, if those at risk of mental health problems are to be identified. The implementation guidance (DoH, 2003) on the Women's Mental Health Strategy recommends that women should routinely be asked about their family and personal mental health histories at the first antenatal appointment. Again, training with regard to both detection of and responses to mental health problems appears relevant.

3.5 Co-ordination and Collaboration Amongst Health Professionals

In order to explore health visitors' and midwives' responses to suspected antenatal depression, a series of open questions was posed addressing liaison and referrals between health professionals. The most common course of action identified by respondents was referral to or discussion with the woman's GP. Over 80 per cent (n=32) of respondents, and all but one of the midwives, identified this as the approach they would follow. These results were confirmed by those respondents who had actually liaised with another professional concerning women who were antenatally depressed – eight out of nine midwives and 11 out of 15 health visitors had liaised with the GP. However, in common with the health visitors who participated in Jeyarah Dent and McIntyre's (2000) study, some respondents were not happy with the quality of the response from the GP. One midwife wrote:

> *Find GPs on the whole not very supportive – usually dismissive.*

Although GPs play a key role in the detection of mental health need in the community and function as the gateway to specialist mental health services, their performance in this field has been criticised as uneven (The Sainsbury Centre for Mental Health, 2003). The majority of respondents (72%) also indicated that they would offer the woman extra support or visits in cases of possible depression. Some specifically described these as 'listening visits'. Of those respondents who had liaised with other professionals, more than half indicated that the outcome of the liaison was extra support for the woman or an increased number

of visits. A number of these additional visits were joint visits with other professionals.

Only six of the 14 midwives indicated that they would discuss possible depression in pregnancy with the health visitor, although 16 of the 25 health visitors said that they would talk to or refer to the midwife. However, of those midwives who actually had liaised with another health professional regarding antenatal depression, only two out of the nine had not discussed the matter with the health visitor. Twelve of the 15 health visitors who had liaised with another health professional had discussed the case(s) with the midwife. Nearly 50 per cent (n=19) of the respondents indicated that they would liaise with the community psychiatric services if they suspected antenatal depression. This number included only nine of the health visitors (36%), but ten of the midwives (71%). However, of those who had liaised in practice, eight of the 15 health visitors had referred to psychiatric services and all but one of the nine midwives. Some respondents found that the women whom they had referred did not always meet the community mental health team's criteria for acceptance as clients and one health visitor commented that:

> *CMHT [Community Mental Health Team] don't often respond – not severe and enduring ...*

Practitioners participating in Stanley *et al*'s (2003) survey of practitioners in child care and mental health services reported similar experiences of community mental health services with regard to mothers with mental health problems.

Only five respondents specifically mentioned the specialist Mother and Baby Link Practitioners within the CMHTs as a possible resource in cases of antenatal depression. However, within the Sure Start teams, three of the ten survey respondents said they would discuss depression with the Mother and Baby Support/Link Worker within Sure Start. This post, although not a specialist mental health post, offers advice and support to families and facilitates contact with other agencies. Four of the seven respondents who had liaised with other professionals had referred to this colleague.

3.6 Awareness of Local Services

Respondents were asked if they were aware of any local services for women suffering from depression in pregnancy, but 54 per cent (n=21) failed to identify any services. Eight of the 18 who were aware of local services named the community mental health team, although only three respondents specifically referred to Dales House or Westlands (North and West Hull's Adult Community Mental Health Teams' bases). Eight respondents mentioned Sure Start as a local resource, with only three of these being from a Sure Start facility. There was little awareness in the respondent group of voluntary sector services, with only one professional mentioning MIND and Women's Centres.

3.7 Resources for Better Detection and Treatment of Antenatal Depression

The survey respondents were asked what resources they felt were necessary for better detection and treatment of depression in the antenatal period. Thirty-one per cent (n=12) specified a need for a routine screening tool that could be used antenatally to assess the woman's mental health status, but there was no common consensus on which stage of pregnancy would be the best time to utilise such a tool. Neither did respondents indicate which particular tool would be most suitable. Some guidance would be required, therefore, concerning appropriate timing and type of screening tool should this be introduced. Tully *et al*'s (2002) study found that only a quarter of maternity units undertook any sort of antenatal screening for depression, with the majority of these choosing to screen at booking. They found that the EPDS was the most commonly used tool and was more likely to be implemented by the health visitor than the midwife.

Thirty-one per cent of respondents (n=12) mentioned the need for more time to spend with women if they were going to be able to detect depression and help women experiencing it. The need for more time for face-to-face contact is reinforced by the views of the women who participated in the focus groups. As noted in the previous section of this report, for the women, more time spent with midwives or health visitors would have been conducive to developing the trust and

familiarity that would promote disclosure of problems.

Only five respondents considered continuity of care or carer as a necessary component in improved detection and treatment of antenatal depression. Midwives and health visitors may not consider the task of developing a relationship with their client as a means of assessing mental health status. Women themselves, however, as seen from the focus group data, regard a good relationship with their midwife (particularly) as central to being able to open up and discuss honestly how they are feeling.

Thirty-three per cent (n=13) of all respondents (including six of the 14 midwives) indicated a need for clear referral routes or pathways in order to improve the treatment of depression antenatally. From the variety of responses received with regard to the course of action taken in suspected cases of antenatal depression, it appear*s* that there is some confusion amongst practitioners about how to proceed if depression is detected. The use of integrated care pathways may be a possible solution, but their effectiveness needs thorough investigation. Twenty-eight per cent of respondents (n=11) felt that a specialist team approach would improve treatment, although it was not always clear what was meant by this term. Some indicated that they would like to see specially trained midwives and health visitors, whereas others wanted a designated Community Psychiatric Nurse to be available for referrals and advice. Whether those already employed as Mother and Baby Link Practitioners within the Community Mental Health Teams would be in a position to take on this role is an area that needs exploring. A small number of respondents (four) highlighted the need for increased awareness among GPs in the area of antenatal depression. This is consistent with some of the views expressed by the women in the focus groups who were not always happy with the responses they received from their GPs with regard to expressing feelings and emotions in pregnancy.

4. Conclusions

This section brings together the findings from the two stages of the study, identifying concurrences and variations in mothers' and practitioners' views where relevant.

4.1 Professional Attitudes and Establishing a Confiding Relationship

Mothers found professionals' attitudes significant in determining whether they felt able to express feelings of depression in the antenatal period. They wanted to be listened to, to be taken seriously and to be treated non-judgementally. The stigma surrounding mental health problems and the expectations placed on pregnant women meant that professionals who did not listen or acknowledge the possibility of negative feelings were considered unlikely to elicit any disclosure of depression from expectant mothers.

Mothers also valued continuity of care/carer from professionals in the antenatal period and saw the quality of a relationship as essential to disclosure of mental health problems surveyed. *Changing Childbirth* (Department of Health, 1993) highlights the importance that should be attached to continuity of care in the perinatal period, as do the NICE guidelines for antenatal care (NICE, 2003). However, in West Hull, it is unlikely that women will receive all their antenatal care from one midwife and the practitioners surveyed attached less significance to continuity of care than the mothers.

The mothers also felt that antenatal procedures, such as weighing and taking blood, could sometimes act as a barrier to the development of confiding relationships. The non-clinical setting and the limited caseloads available to the Sure Start teams appeared to have the effect of increasing staff's perceived availability and accessibility for mothers. Sure Start also promote a non-judgemental ethos which the focus group members identified as key to the disclosure of emotional or psychological problems.

Midwives' awareness of the features of depression in the antenatal period was slightly less developed than that of health visitors. Health visitors are likely to have been sensitised to the symptoms of depression by their focus on postnatal depression. Both groups of practitioners appeared to consider a limited range of emotional and social factors in their work with pregnant women and would benefit from further training in this area.

4.2 Working Together in Antenatal Care

The majority of those surveyed agreed that midwives were the lead professional in the field of antenatal care. However, midwives were slightly less likely to see themselves liaising with health visitors with regard to women suffering from antenatal depression than health visitors anticipated liaising with midwives. This may be a reflection of community midwives' lack of confidence in identifying and responding to ante-natal depression. Training programmes in this area should address the importance of communicating with other professionals and could perhaps be offered on an interprofessional basis.

GPs were the professionals who both midwives and health visitors were most likely to contact in cases of suspected antenatal depression (This result is consistent with the findings of Tully *et al,* 2002). However, some respondents were disappointed in the response from GPs. Mothers also provided some evidence of GPs' unsatisfactory performance in this area, citing a failure to listen or take mothers seriously as key problems.

Half the midwives surveyed said they would contact the Community Mental Health Team (CMHT) in cases of antenatal depression. However, very few identified the specialist Mother and Baby link practitioners from the CMHTs as appropriate contacts. A number of respondents noted that women who were referred to CMHTs failed to meet the service's 'severe and enduring' criteria and consequently did not receive a service.

Health visitors and midwives appeared to have little awareness of community-based services, other than Sure Start, which might offer support to women with antenatal depression. While this might reflect a lack of services specifically targeted at this group, it is surprising that more widely targeted services such as Homestart and MIND were not seen as relevant in this context. Low awareness of local support services may contribute to professionals' reluctance to identify antenatal depression as a possible issue. As Stewart and Henshaw (2002) point out: *'Midwives may be reluctant to open a Pandora's box of matters they are not sure how to deal with or who to refer to'* (p.118).

5. Recommendations

5.1 Detecting Antenatal Depression

Midwives' awareness of, and ability to detect, antenatal depression needs to be increased. The introduction of a screening tool might have some impact on both of these (Clark, 2000). However, there is a danger that the use of a screening tool could constitute a barrier to the development of a confiding relationship between the midwife and patient, in the same way that weighing and taking blood were described by mothers as impeding communication. A series of social and psychological indicators, such as that developed in Glasgow (see box below) might be more useful in this respect. Locally, Sure Start have piloted an initiative in the Marfleet area of Hull using a questionnaire which also offers some possible indicators.

Screened to identify antenatal risk factors for postnatal depression indicators

	YES	NO	date/initial
Current symptoms of Depression	□	□	
Previous depression	□	□	
Lack of social supports	□	□	
Lack of confiding relationship	□	□	
Recent stressful life events	□	□	

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5.2 Interprofessional Training

Training needs to be delivered to all those staff involved in antenatal care to develop knowledge of antenatal depression, referral routes, and relevant local services. There are examples of areas where such training has already been introduced (see Wheatley *et al*, 2003; Bolton *et al*, 2001). It is recommended that training should be interprofessional and should include GPs who play a key role in diagnosis and in securing access to mental health services.

5.3 Flexible Caseloads

Midwives need to have the capacity to negotiate their caseloads in order to be able to spend additional time with women who may be at risk of or experiencing antenatal depression. This flexibility is currently available to Sure Start staff but not to those employed in mainstream services. The benefits of this model need to be transferred across to NHS practitioners.

5.4 Co-ordinating Antenatal Care

In the long term, the work of midwives and health visitors could be more effectively co-ordinated by bringing them together in integrated community-based teams. The forthcoming introduction of extended schools may offer opportunities for such developments.

5.5 Building Expertise in Mental Health

Locating specialist mother and baby CPNs with community health workers would offer a means of developing an effective response to antenatal depression. Such a structure would spread expertise and promote the confidence of community health workers in this field. It would also provide a strong link between community health and mental health services. This study did not include hospital midwives but they also need to have access to mental health expertise and awareness.

5.6 Joint Planning

West Hull PCT needs to work with community mental health services to define the criteria used to access services for both expectant mothers and those with young children. A focus on high risk and 'severe and enduring' mental illness has the effect of excluding from services many women whose mental health needs are conceptualised as 'reactive'. However, the perinatal period is the period when women are most at risk of developing mental health problems and the long-term impact on them and their children may be considerable (Department of Health, 2002). Mental health services and PCTs need to undertake joint planning to ensure that mothers have access to relevant services in the antenatal period.

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Appendix 1 Vignettes used to assess professionals' awareness of antenatal depression

Please read the statements below and rate how normal you think these feelings are in pregnancy, where 1 is completely normal and 7 is very unusual.

I feel tired a lot of the time and find it difficult to get going in the mornings. 1 2 3 4 5 6 7

I'm very frightened about the birth – I'm worried that I won't be able to cope. 1 2 3 4 5 6 7

I'm 6 months pregnant and I feel devastated. Having a baby is the worst thing that could happen to me. 1 2 3 4 5 6 7

I cry every day and can't get the dread of being a mother out of my head. 1 2 3 4 5 6 7

I'm going to have my baby in 4 weeks' time - what if I'm not a very good mother? I don't really know what to do. 1 2 3 4 5 6 7

I'm 3 months pregnant and I feel so scared. I sometimes wake up in the middle of the night, rigid with panic. 1 2 3 4 5 6 7

I have felt very low over the last few weeks. I don't seem to be able to look forward to anything. 1 2 3 4 5 6 7

I'm due in 2 weeks' time and I'm anxious about the baby. Will it be all right? 1 2 3 4 5 6 7

I'm 5 months pregnant and everybody says I should be blooming, but I don't feel at all like that. 1 2 3 4 5 6 7

I feel totally numb. Sometimes I just wish it would go away. 1 2 3 4 5 6 7

My emotions are all over the place – one minute I'm laughing, the next I'm crying. 1 2 3 4 5 6 7

The baby is due next month, but I wouldn't really care if I lost it – I'm just going through the motions. 1 2 3 4 5 6 7

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