

NEW ZEALAND RESEARCH

Midwives' perspectives of maternal mental health assessment and screening for risk during pregnancy

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ABSTRACT

Background: Increased maternal mental health needs are associated with an increased risk of maternal morbidity and mortality and occur more frequently during pregnancy than during the postnatal period. The implications of this antenatally for the mother, baby and family is increasingly becoming recognised and recommendations are being made for routine antenatal screening.

Aim: This qualitative descriptive research study explored midwives' perceptions of maternal mental health antenatally, including screening.

Method: Twenty-seven Lead Maternity Carer (LMC) midwives participated in five focus group interviews. These were analysed using thematic analysis to identify the key ways in which midwives perceived and assessed maternal mental health during the antenatal period.

Findings: The study identified that these midwives routinely assessed women's mental health during antenatal care in informal and not necessarily explicit ways. Caring for women who were highly anxious was not an infrequent experience and led to the midwives feeling responsible for the woman's mental health needs without a safety-net. Midwives were concerned about the introduction of routine universal antenatal screening without the availability of appropriate maternal mental health services for women who had identified as having mild to moderate mental health issues, such as anxiety.

Conclusion: The mental health services that the midwives needed to refer pregnant women experiencing mental health issues to, particularly those women with mild to moderate issues, are lacking. We suggest that the introduction of routine antenatal mental health screening would need to be well supported with accessible and appropriate mental health services to meet the needs of all women, not just those experiencing serious mental ill health.

Keywords: maternal mental health, antenatal assessment and screening, antenatal anxiety and depression, midwives' perspectives

INTRODUCTION

A degree of anxiety and stress is often considered normal in the perinatal period but for some women anxiety can become a serious problem and affect their health and wellbeing (Stadtlander, 2017). Anxiety and depression during pregnancy often coexist (O'Hara, Wisner, & Asher, 2014; Schmeid et al., 2013) and are associated with postnatal depression (Koutra et al., 2014; Obgo et al., 2018). Antenatal stress, anxiety and depression represent key risk factors in the aetiology of preterm birth (Eastwood, Obgo, Hendry, Noble, & Page, 2017; Rose, Pana, & Premji, 2016; Staneva, Bogossian, Pritchard, & Wittkowski, 2015). An association has also been identified between antenatal stress, anxiety and depression and low birthweight infants (Khashan et al., 2014; Saeed, Rashid, Ahmed, Naqvi, & Tabassum, 2016).

Maternal mental health morbidity can continue well beyond the perinatal period with antenatal stress, anxiety or depression also associated with a negative effect on the cognitive development, behaviour, and emotional health of the child (Glover, 2015; Leis,

Heron, Stuart, & Mendelson, 2014; Slykerman et al., 2015). High levels of antenatal stress, anxiety or depression have been found to be associated with behavioural problems and depression in the offspring at age 21 years (Betts, Williams, Najman, & Alati, 2015).

The Growing Up in New Zealand study (n=5664) is a longitudinal study which found that 11.9% of participants had symptoms of antenatal depression/anxiety (Waldie et al., 2015). In a more recent phase of the study (n=5301) Underwood, Waldie, D'Souza, Peterson and Morton (2017) found that 16.5% of this cohort reported significant symptoms of depression either at booking or at nine months postpartum, with more women meeting the criteria for depression antenatally. Almost 26% of women in this cohort who experienced antenatal depression also had postpartum depression.

Suicide is a leading indirect cause of perinatal maternal death in New Zealand. The Perinatal and Maternal Mortality Review Committee (PMMRC, 2016) in its review of the 22 maternal

deaths from suicide (2006-2013) found that many of these women had risk factors for major depression that were not recognised. Thirty-two percent of these deaths were considered to have been potentially avoidable.

There is a growing body of evidence indicating the importance of maternal mental health assessment and screening antenatally, as well as during the postnatal period, and the provision of appropriate services to meet women's needs. However, maternal mental health needs are not always recognised (Bayrampour, 2018; Burgess & Shakespeare, 2016).

According to the United Kingdom (UK) Centre for Mental Health, the costs incurred as a result of perinatal mental health problems in the UK equate to five times the cost of improving the services. An estimated 28 percent of these costs relate to the mother, and 72 percent to the child. Child outcomes calculated included pre-term birth, emotional problems, conduct problems, special education needs, and chronic abdominal pain. Related maternal costs included lost income, bills for health and social care, and economic effects related to suicide. It was also recognised, although not included in the cost calculation, that the potential impact of untreated perinatal mental health needs ripples out more extensively, influencing, for example, partners, employment and children being taken into care (Centre for Mental Health, 2014).

Early identification of increased perinatal mental health needs and referral to appropriate services benefit both the mother's mental health and wellbeing and also the health and development of the infant (Eastwood et al., 2017). Maternal mental health screening should be a routine part of antenatal care (New Zealand Guidelines Group, 2008; PMMRC, 2018). The National Institute for Health and Care Excellence (NICE) guidelines (2014) recommend that all women are routinely screened for maternal mental health problems at their first antenatal appointment and again early in the postnatal period, and that the woman's mental and emotional wellbeing is assessed at each encounter.

There is no formal perinatal maternal mental health assessment/screening programme in New Zealand (Ministry of Health, 2018). The National Maternity Monitoring Group (2017) has recommended that all District Health Boards (DHBs) throughout New Zealand develop maternal mental health referral pathways to guide assessment and screening throughout the perinatal period and to aid referral to appropriate services.

BACKGROUND

Midwives are integral to the success of maternal mental health assessment and screening during pregnancy due to their pivotal role in antenatal care.

There are no New Zealand studies examining how midwives perceive their role in maternal mental health or their antenatal assessment and screening practices. However, studies from Australia and the UK identify midwives' perception of their knowledge of maternal mental health, attitudes towards caring for women with maternal mental health needs, their preparedness for their role in identifying risk, and their perinatal (rather than just antenatal) assessment and screening practices. In a systematic review exploring the barriers and enablers for women with symptoms of depression seeking help postnatally, the authors found that when health professionals were supportive and sensitive, and validated the woman's concerns about her mental health, this enabled her to share her feelings and accept referral to services more readily (Newman, Hirst, & Darwin, 2019). Hauck et al. (2015) explored 238 Australian midwives' attitudes towards perinatal mental health, finding generally positive attitudes,

although a small cluster analysis indicated that there was some negative stereotyping of women with mental health needs by some of the midwives.

An integrative review of 20 studies (predominantly from the UK and Australia) by Bayrampour (2018) found that midwives' attitudes towards maternal mental health could be a significant barrier to midwives' screening. Although midwives generally perceived that their attitudes towards women with mental health needs were compassionate, empathetic and respectful, some negative attitudes, reflecting the impact this had for the midwives' workload, were reported. The findings of this review also highlighted that time pressure to prioritise physical over mental health care was a significant barrier to midwives' screening, and that managing subsequent referrals and care of women with mental health needs may cause stress for some midwives.

Whilst generally midwives acknowledge their integral role in caring for women with mental health needs, this is compromised by feelings of lacking the skills to deal with maternal mental health problems, and a lack of adequate educational and organisational support and referral options (Hauck et al., 2015; McGlone, Hollins Martin, & Furber, 2016; Noonan, Doody, Jomeen, & Galvin, 2017). In their integrative review of 22 publications (17 of the 22 from Australia and the UK) Noonan et al. (2017) explored midwives' perceptions of their role in supporting women with perinatal mental health needs. The review found that the midwives' perceived lack of confidence and competence in this area, along with a lack of practical support systems, were fundamental to their readiness to support women with their mental health needs. Central to the midwives' confidence and practice was the availability of appropriate and accessible mental health services.

A scoping review of 26 publications from Australia, the United States and Europe (21 of the 26 from Australia and the UK) exploring midwives' and women's perceptions of barriers to accessing mental health services found that many of the midwives lacked confidence around when and how to talk about mental health needs, resulting in inconsistent screening practices (Viveiros & Darling, 2019).

Findings from recent studies of midwives in Ireland also highlight inconsistent screening practices. Noonan, Jomeen, Galvin and Doody (2018) found that 77% of midwives in their study ($n=157$) did not use a screening tool to screen for maternal mental health needs. Carroll et al. (2018; $n=438$) also found variation in screening practices, with midwives only screening women who they considered may be at risk, potentially resulting in a lack of identification of mental health needs. They also identified challenges to midwives' screening which included heavy workload, time constraints, and a lack of care pathways and maternal mental health services. Similarly, Higgins et al., (2018) in their study ($n=837$; 438 were midwives) found heavy workload, lack of time with each woman, and lack of clear mental health pathways were key barriers to midwives discussing mental health with women.

As the New Zealand model of midwifery differs from that of many other countries, it is important that research captures the practices and perceptions of New Zealand midwives. Given the evidence and recommendations for routine antenatal maternal mental health screening, and midwives' place in the provision of antenatal care, it seemed timely to explore local midwives' views on maternal mental health and its antenatal assessment. This study had a particular focus around needs that are considered to be mild or moderate in nature which do not meet the criteria for referral to the Maternal Mental Health (MMH) service.

METHODS

Thorne's (2008) interpretive description methodology was used for this study. It was designed for use in the applied health sciences, and is grounded in these professional epistemological foundations (Thorne, Kirkham, & MacDonald-Emes, 1997). Interpretive description facilitates the generation of knowledge by the discovery of themes and patterns within the research data which can then be used to assist in clinical reasoning, and to guide and inform clinical practice (Hunt, 2009; Sandelowski, 2000; Thorne, 2008). Researchers using this methodology are concerned with both descriptive validity in accurately describing the events, and interpretive validity, which comes with accurate accounting of participants' meanings that are evident within the event (Sandelowski, 2000). This methodology is particularly useful when researchers strive to know the "who", "what", "where", and "how" of a phenomenon (Sandelowski, 2000).

Ethical considerations

Ethical approval for the study was obtained through the Auckland University of Technology Ethics Committee in 2014 (Approval number 14/86). Participant Information forms were emailed to midwifery practices to invite potential participants. Interested midwives then contacted the first author and, following confirmation of their interest, a time and place for a focus group interview was arranged.

At the commencement of each focus group interview, the study was again outlined and then written consent sought from each participant. Before each interview began ground rules were established to ensure that participants felt safe to share their perspectives and experiences with their peers. These included agreeing to the identity of group members and information provided remaining confidential to the focus group members and the first two authors. Confidentiality was further maintained by assigning each participant an identification number and the removal of any identifying information from the transcripts.

Participants

A purposeful sample of 27 Lead Maternity Care (LMC) midwives was recruited and each midwife took part in one of five focus groups. The participants worked in a variety of settings in the Auckland region. Our rationale for recruiting such LMCs was to capture the issues related to maternal mental health across the continuum from pregnancy, labour and birth through to the postnatal period. This ensured that the midwives studied were making clinical decisions about antenatal maternal mental health assessment and screening and would have experience of caring for women with maternal mental health needs. This cohort included midwives who regularly cared for Māori, Pacific and Asian women, those who did homebirths, and those from both urban and rural practices. Our aim was to maximise insight into the perceptions and practices of these midwives with regard to maternal mental health (Table 1).

Data Collection

Our use of focus groups aimed to capitalise on the interactions amongst the members of each group. The ensuing discussion revealed both the similarities and differences amongst the LMCs regarding their perceptions of maternal mental health and their individual antenatal assessment and screening practices. The number in each group ranged from two to seven. CM facilitated and DP took notes to assist transcription and ensure that the aspects of LMC practice were addressed. The focus groups were digitally audiotaped and later transcribed by CM.

At the beginning the LMCs were asked to share their views of what constituted a state of mental health and wellbeing. Then, they were asked to talk about their practice in relation to maternal mental health: how they assessed a woman's mental health during pregnancy, and what they did when their assessments indicated that a woman's mental health and wellbeing required support.

Table 1. Participants' demographic information

Focus group 1	7 LMC midwives	Supported women giving birth in primary settings	Rural practice
Focus group 2	6 LMC midwives	Supported women giving birth in primary and secondary settings	Urban/semi-rural practice
Focus group 3	6 LMC midwives	Supported women giving birth in secondary settings	Urban practice
Focus group 4	2 LMC midwives	Supported women giving birth in primary and secondary settings	Semi-rural practice
Focus group 5	6 LMC midwives	Supported women giving birth in primary settings	Rural practice

Data analysis

The four-stage cognitive process for qualitative data analysis by Morse and Field (1995) was used to drive the data analysis for this research (Table 2). Transcripts were analysed by CM using a stepped process of first making sense of the data and asking, "What is going on?" (Thorne, 2008). Next the data were systematically sorted and synthesised looking for categories or explanations. These notes became more definite and polished as the analysis developed and the underlying meaning became more evident. From there the patterns, then the categories and themes, were identified.

Table 2. Four-stage cognitive process for qualitative data analysis and its application to this research study

Stage of data analysis	Meaning	Application of data analysis stages to this research study
Comprehension	Making sense of the data and asking, "What is going on?"	Repeatedly listening to narratives Immersion in the data Reflection on own pre-suppositions Searching for insights Notes to capture non-verbal communication within data Primary researcher transcribed focus group interviews
Synthesising	Systematically sorting the data and beginning to look for significant patterns	Transcripts analysed in detail Memo notes remained broad Potential meaning teased out
Theorising	Reflective process constantly challenging the interpretive angle until patterns in the data and ideas become more refined and themes are identified	Notes became more polished Areas identified that were salient for development of clinical reasoning Memo notes that had begun to form categories collated and placed on left side of series of Word documents On right side of documents associated meaning further teased out Contradictory notions carefully examined, compared and contrasted
Re-contextualising	Reflection on themes and over-arching statement	Holistic reflection on themes considering clinical application and reasoning

Rigour

Guba and Lincoln's (1981) framework for achieving trustworthiness was observed throughout the study (Table 3). Anonymised transcripts of the focus groups' discussions were initially shared with DP, and beginning codes cross checked. Later codes, themes and interpretation were crosschecked with the research team.

Table 3. Framework for trustworthiness in qualitative research and its application to this research study*

Criterion	Meaning	Application to this research study
Credibility	Confidence in the 'truth' of the research findings	Study originated from gaps identified in the literature review Purposive sampling of 'key informants' Prolonged engagement with data Accurately capturing and describing the participants' perspectives
Confirmability	Neutrality and accuracy of the data Certainty that findings have been determined by the subjects and context of the research	Ongoing reflexivity (researcher) Member validation during focus group interviews for clarification of meaning Ongoing discussion throughout analysis with supervisors
Dependability	Would the findings be repeated if the research was replicated with the same (or similar) subjects in the same or similar context?	Keeping a decision trail throughout research study including rationale for decisions & analytical process Clearly articulated and transparent research process Ongoing self-reflection (researcher)
Transferability	Application of the findings to other context or with other groups	Rich description of findings capturing underlying meaning in a way that readers can recognise and relate to their own practice

* Lincoln & Guba (1985)

FINDINGS

The overarching theme "the disparity between needs and service provision" was underpinned by three sub-themes: "not meeting needs", "the anxious woman needing extra support", and "safeguarding women's wellbeing and welfare", thus providing an overarching statement of "holding the problem: plugging the gap between women and the service". The midwives found that appropriate services were not always available to meet the needs of women who had symptoms such as anxiety and mild/moderate depression, which did not meet the criteria for referral to the MMH service. As a consequence, there was a gap between the needs of the women and services available to them, which left the midwives carrying the weight of attending to these women's mental health needs.

Not meeting needs

Carrying the weight of the woman's maternal mental health needs appeared to impact on the continuum of care from mental health assessment/screening to accessing services. The participating midwives felt that the current service was not meeting the needs of all women, and consequently neither was it meeting the needs of midwives; these being that, following a concerning assessment, they are able to refer to services and gain appropriate care for women.

Identifying the maternal mental health needs

The midwives acknowledged their pivotal role in the assessment of maternal mental health in the antenatal period. Whilst the

antenatal assessment and screening practices across the range of midwives were not cohesive, there were commonalities. All of the midwives incorporated some form of ongoing enquiry as part of their antenatal care, continually assessing women's mental health throughout the pregnancy (all names are pseudonyms to protect the privacy of participants):

It might seem like you're just sitting down having a chat, but actually you're taking in all the little facial nuances, you've taken in the home situation without looking like that's what you've done, you've taken in what does the relationship seem like, you take in so much more than what you actually let on. (Isabelle)

Yes, I do a bit of both [maternal mental health assessment and screening at booking and later in pregnancy]. There are definitely screening questions that you do at the beginning, often at booking, and then maybe as you are getting a bit of an inkling something's not right, or just a couple of times in the pregnancy if you're not quite sure. (Grace)

Although it is not explicitly stated, Isabelle's assessment of a woman's mental health was constant and integral to her midwifery care. She subtly assessed the woman's state of mental health, looking for signs that might indicate a mental health need. In the example above, Grace mentioned that when she got "an inkling" that something was not right, this was a catalyst for further assessment or screening. This highlighted that she was drawing on different cues and subtly assessing the woman's mental health. The midwives' assessment was often not formal in nature but was a thread that was woven into midwifery care, reflecting a holistic approach.

The midwives spoke about how the routine questions about the woman's and her family's mental health, required as part of the midwives' health assessments, represented a catalyst for further enquiry, providing a space for conversation about mental health. Beyond this, formal antenatal MMH screening was not routine. The majority of the participant midwives used the Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987) selectively, as a vehicle for validating their existing concerns, and to validate referral to the MMH service. Many of the participants challenged the efficacy of a routine antenatal screening programme without having the support of appropriate services. They identified that there was a threshold where they felt the responsibility for the woman's mental health needs should be met by appropriate mental health services. However, these services were often not easy to access.

Difficulties accessing services

Although the referral guidelines for midwives (Ministry of Health, 2012) provide guidance for maternal mental health referral, this was not always effective in ensuring that all women's needs were met, particularly when their symptoms did not meet the criteria for referral to the MMH service. The midwives felt dissatisfied and frustrated by the current referral process:

I had one (woman) that had a previous pregnancy loss and she was incredibly anxious with her subsequent pregnancy. I referred her to MMH service, and they didn't pick up the ball at all. I think they gave her one phone call...and I was seeing her weekly from the beginning of the pregnancy, and my scheduled appointments never ended up the time I booked for her. It was counselling for the whole pregnancy. (Emily)

I've had a couple where they're just 'No, she doesn't need it', or 'She doesn't qualify, you need to ring this person, you need to ring this person', you get a bit of a runaround. Who am I supposed to be calling about this lady? (Lisa)

Once a woman's symptoms and behaviours related to mental health needs became apparent to them, it was not uncommon for the midwives to experience difficulties in locating services that could support her. Sometimes they felt that the woman needed care from the local DHB mental health service who, while they followed up the referral, only accepted women who met their admission criteria. Central to the midwives' discussions were women who were anxious and required additional support and reassurance; this became a further sub-theme.

The anxious woman needing extra support

Whilst acknowledging that some degree of anxiety was to be expected during pregnancy, participants all commented on the prevalence of heightened anxiety symptoms evident amongst women in their care. They considered that this state of anxiety was often consequently normalised due to its pervasiveness. They noted that it was them who provided the additional psychological support and reassurance that these women needed to allay their anxiety, which subsequently resulted in a greater workload and pressure for the midwives:

I've got a couple of women at the moment who have been texting me a lot, and one of them, I think I counted 18 texts in a three-week period . . . they're just 'I did this and it made me worried' and 'Did I hurt the baby' and 'Do you think if I did this and did that, and ate this and it wasn't hot enough then', you know? (Jenny)

The midwives were carrying the weight of the women's anxiety in the absence of appropriate services. This was seen as having a significant impact on their workload, both in and outside of "normal hours". Reducing women's anxiety also became a variable for midwifery decision-making:

And I find that getting the balance right, of doing testing just to reassure them, then often the testing (of fetal wellbeing) itself brings up more anxiety. Its (fetal growth) on the tenth percentile but everything's fine, but they are, you know? One of them, the baby was meant to be 2.8 kg and it came out at 3.2kg Did I cause more anxiety by doing that scanning, which I didn't really need or want to do? But I did it thinking that I would set her mind at rest, and it didn't. Those kind of things, juggling that discretionary part of it too . . . You think you're reassuring them, and then it backfires on you, and suddenly they're more anxious. (Charlotte)

Sometimes the midwives offered additional assessment/screening purely to satisfy the woman's need for reassurance about her pregnancy. This had the potential to create additional work and uncertainty for the midwives without always effectively reducing the woman's anxiety.

Safeguarding women's wellbeing and welfare

The midwives had some key concerns regarding safeguarding women's wellbeing and welfare whilst carrying the weight of women's mental health needs. Plugging the gap between the woman's needs and service provision had implications for the midwives.

Trusting relationship and feeling responsible without a safety-net

The midwives felt an additional responsibility, and frequently the absence of a safety-net, as they filled in the service provision gap in order to safeguard the woman's wellbeing. This was influenced by the relationship between the midwife and the woman,

which appeared to facilitate women's reliance on the midwives for support:

I wasn't meant to be going to see her but how could I not have gone to see her? She didn't have anyone else that she talked to (...). I really do feel that the system let her down. When she was out in the community it didn't seem that there was regular contact, kind of like, 'We've fixed you, here's your tablets, on your way'. She should have had a wrap-around service, which leaves you carrying a really big burden when you feel someone's been lost because there weren't proper safety-nets. (Rosie)

I'm a midwife (...) I'm not a counsellor. I think it's really hard because people want you to be their social worker, their aunty and friend, as well as a midwife, and I think that's such a burden to carry. (Frances)

When the midwives were left carrying the weight of the woman's mental health needs they felt responsible beyond their midwifery obligations and without a safety-net. They felt that women's expectations of their support were intensified by the trusting relationship they shared, but also reflecting the lack of services to meet these needs.

Feeling ill-prepared

When having to plug the gap between women's maternal mental health needs and available services, many of the midwives felt ill-prepared to provide appropriate care:

Yes, I find it difficult sometimes. We have a postnatal woman at the moment (who has maternal mental health problems); we didn't get a lot of help with her. So, I feel tricky because I don't know enough about it and I don't know when and how to ask. If something crops up it's very difficult to say, well what do you say to somebody who you think is not coping, apart from, 'You're not coping? Do you need to see these people?' And she's refusing everybody. Maternal Mental Health spoke to her on the phone, and she was fine, so yes, it's a bit like that. (Caroline)

Yes, I think we need some more training (maternal mental health) that would prepare midwives for what it's like (in clinical practice). And around managing those really difficult women who are really anxious, that's very hard to deal with. (Nina)

Being left carrying the weight of maternal mental health needs, and feeling frustrated and unsupported by services, strongly influenced the midwives' perspective of feeling ill-prepared for their current practice reality. There was an underlying concern that midwives were unable to provide the additional support needed by the woman. This, they believed, needed to be provided by mental health workers, not midwives.

DISCUSSION

Themes from this research show that the disparity between women's needs and maternal mental health service provision was central to the midwives' frustrations around carrying the weight of women's mental health needs. Feeling responsible for the care of these women, who although struggling did not meet the criteria for referral to the MMH service, impacted on the midwives.

The evidence from this research suggests that one effect of the gap between women's needs and the services available to them was that the process of referral was not always seen as a reliable one, in that it did not always result in a woman receiving the support that she required. Identifying and referring a woman who "only" had

a mild or moderate mental health issue was problematic in that, because of the lack of appropriate services, the obligation or onus of ensuring the woman's wellbeing then fell on the midwife. Hence, having an available service that met the mental health needs of all women, and not solely for those with more serious mental health issues, would not only validate the purpose and meaning of the assessment and screening but also make it worthwhile.

Although universal routine antenatal mental health screening and psychosocial assessment have been recommended (New Zealand Guidelines Group, 2008; National Institute for Health and Care Excellence, 2014; Perinatal and Maternal Mortality Review Committee, 2018), universal screening alone may not represent a complete solution. Laios, Rio and Judd (2013) emphasise the importance of mental health being integral to maternity care, and its assessment being ongoing rather than relying on a transient screening tool. It is important, also, that screening tools are not purely a "tick box exercise", a potential barrier to the woman engaging with her midwife, but instead are used as a vehicle to facilitate deeper discussions with women about their mental health and wellbeing (Viveiros & Darling, 2019).

Findings from this research show that our participant midwives did perform ongoing assessment of women's mental health, which would complement a universal routine screening programme. The findings show that, although for the majority of the midwives antenatal screening using a tool such as the Edinburgh Postnatal Depression Scale (Cox et al., 1987) was not routine, the required questions about the woman's past and present mental health, along with her family history, effectively lead to an initial assessment. If routine screening, such as is recommended, is implemented then more services will need to be available.

Maternal mental health should not be regarded as a separate entity but, instead, its evaluation should be normalised and embedded into routine maternity care (Atif, Lovell, & Rahman, 2015). Assessing a woman's physical and psychological symptoms simultaneously would help with this normalisation. To facilitate greater integration, the MMH services need to work in partnership with midwives, addressing the woman's symptoms of anxiety and depression and lifting the weight from midwives.

Findings from this research suggest that the trusting relationship between midwives and women could be both "friend and foe". The trusting relationship central to the continuity of care model has been acknowledged as being critical to identifying maternal mental health needs (Viveiros & Darling, 2019). However, this research suggests that the relationship sometimes created additional workload and pressure for the midwives. The participant midwives cared deeply for the women in their care, and this motivated them to "plug the gap" between the women's needs and the service deficit.

This research highlighted the significant impact, that frequently caring for women who were anxious during pregnancy, had for the midwives' workload and practice. Midwifery is acknowledged as emotionally challenging, and increasingly midwives care for women who are distressed by anxiety, fear and trauma symptoms, which may contribute to burnout and trauma experienced by midwives (Creedy, Sidebotham, Gamble, Pallent, & Fenwick, 2017). In their large cross-sectional survey of Australian midwives (n=1037) Creedy et al. found that 43.8 percent of participants reported work-related burnout, and 10.4 percent reported client-related burnout. Caring for a greater number of women experiencing multiple psychosocial needs can contribute to midwives' emotional stress and burnout (Mollart, Skinner, Newing, & Foureur, 2013).

Furthermore, a New Zealand study of midwife burnout by Young (2011) highlighted the difficulties inherent in ensuring that professional boundaries in LMC practice are not breached when endeavouring to meet women's needs and expectations. Young identified maintaining professional boundaries as necessary to sustainability in LMC midwifery practice.

Studies in Australia and the UK have suggested that many midwives do not feel equipped with the required knowledge and skills for maternal mental health assessment and care (see, for example, Hauck et al., 2015). Some additional postgraduate education, equipping midwives with practical skills for dealing with the symptoms and behaviours that they commonly see in practice, would be of benefit.

The referral guidelines (Ministry of Health, 2012) clearly define the midwifery scope of practice as identifying the maternal mental health needs and referring to the appropriate service. As suggested in this study, there appears to be inadequate services catering for pregnant women who are experiencing mild to moderate mental health issues such as anxiety. Given that anxiety can contribute to ill-health in the perinatal period and beyond, the provision of such services is vital. The dearth of services to meet the requirements of women with mild or moderate mental health needs is therefore the precursor to midwives feeling unprepared for their current position rather than a lack of educational preparation. Women need access to appropriate maternal mental health services both antenatally and postnatally, particularly in primary care. For some women these services are crucial for their safety and wellbeing and that of their baby (National Maternity Monitoring Group, 2017). The New Zealand government has recognised the underfunding of mental health services, inequalities in outcomes, and high suicide rates in New Zealand, and has reinstated an independent Mental Health Commission. A Mental Health and Addiction Inquiry (New Zealand Government, 2018) has been done to assess the efficacy of current mental health service provision.

STRENGTHS AND WEAKNESSES

This study was conducted in a region of New Zealand, so reflects the New Zealand partnership model of midwifery care. The participants were recruited from a range of geographical areas across the Auckland region. Urban, rural, and semi-rural practices were involved. Practices offering care in hospital, in primary birth units, and homebirths were included in the study in an attempt to explore possible diversities in the midwives' perceptions or assessment practices. Existing midwifery practice members formed the focus groups, which proved to be a strength; their connectedness and shared experiences assisted with conversations and collective sense-making.

As this study was conducted with a small sample size in one region of New Zealand, the findings cannot be generalised.

CONCLUSION

Untreated antenatal anxiety and depression is a strong predictor of postnatal mental health issues and can cause significant morbidity and distress antenatally, postnatally and beyond. This study has shown that the participant midwives did assess women's mental health during pregnancy; however, there were not always mental health services they could readily refer these women to, should there be a concern. Should routine antenatal screening be introduced and required universally, then this would need to be well supported with accessible and appropriate mental health services to meet the needs of all women.

ACKNOWLEDGEMENTS AND CONFLICT OF INTEREST DISCLOSURE

We extend our sincere thanks to the midwives who took part in this study, giving their time and insights.

The authors declare that there are no conflicts of interest.

Key messages

- Midwives assess women's mental health throughout pregnancy but can only refer those with serious needs to the maternal mental health service.
- Midwives feel responsibility beyond midwifery care for women with mild to moderate needs, such as anxiety.
- If formal routine screening is introduced, it needs to be well supported by referral into services that all women can access.

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