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Antenatal mental health referrals: Review of local clinical practice and pregnant women's experiences in England

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Abstract

Objective: To investigate: i) the consistency and completeness of mental health assessment documented at hospital booking; ii) the subsequent management of pregnant women identified as experiencing, or at risk of, mental health problems; and iii) women's experiences of the mental health referral process.

Design: Mixed methods cohort study

Setting: Large, inner-city hospital in the north of England

Participants: Women (n=191) booking at their first formal antenatal appointment; mean gestational age at booking 13 weeks.

Methods: Women self-completed the routine mental health assessment in the clinical handheld maternity notes, followed by a research pack. Documentation of mental health assessment (including assessment of depression symptoms using the Whooley and Arroll questions, and mental health history), mental health referrals and their management were obtained from women's health records following birth. Longitudinal semi-structured interviews were conducted with a purposive sub-sample of 22 women during and after pregnancy.

Findings: Documentation of responses to the Whooley and Arroll questions was limited to the handheld notes and symptoms were not routinely monitored using these questions, even for women identified as possible cases of depression. The common focus of referrals was on the women's previous mental health history rather than current depression symptoms, assessed using the Whooley questions. Women referred to a Mental Health Specialist Midwife for further support were triaged based on the written referral and few met eligibility criteria. Although some women initially viewed the referral as offering a 'safety net', analysis of health records and subsequent interviews with women both indicated that communication

regarding the management of referrals was inadequate and women tended not to hear back about the outcome of their referral.

Key conclusions and implications for practice: Mental health assessment was introduced without ensuring that identified needs would be managed consistently. Care pathways and practices need to encompass identification, subsequent referral and management of mental ill-health, and ensure effective communication with patients and between health professionals.

Keywords

perinatal mental health; Whooley questions; screening; antenatal care; midwifery; mixed methods

Highlights

- Mental health referrals focussed on mental health history, not current symptoms
- Midwives did not consistently respond appropriately to Whooley responses
- Local threshold for support was set high due to overburdened systems
- Some women who met the national criteria were deemed ineligible for local support
- Women viewed referral as a ‘safety net’ but were usually not informed of outcome

Introduction

Perinatal mental health problems (i.e. those continuing or recurring in the period spanning pregnancy through to the first postnatal year) are associated with adverse outcomes for women and their babies (Beijers et al., 2010; Johnson and Slade, 2003; Talge et al., 2007; Van den Bergh et al., 2005). A recent meta-analysis showed that women who were vulnerable to develop, or had elevated symptoms of, depression, anxiety or other constructs of ‘maternal distress’ benefit from treatment interventions during pregnancy (Fontein-

Kuipers et al., 2014). Clinical guidelines in England, Scotland, USA, Australia, and Canada recommend that women at risk of mental health problems in pregnancy should be identified early in pregnancy and managed appropriately (American College of Obstetricians and Gynecologists, 2006; Carroll et al., 2005; National Collaborating Centre for Mental Health (NCCMH), 2007; Scottish Intercollegiate Guidelines Network, 2012).

In England and Wales, severe mental illness (severe depression, schizophrenia, bipolar disorder, psychosis in the postnatal period) is the remit of specialist services whereas prevention and treatment of mild-moderate disorder is managed mostly within primary care (NCCMH, 2007). The National Institute for Health and Clinical Excellence (NICE) guidelines in England and Wales recommend that women who meet the criteria for current diagnosis of mild-moderate disorder receive self-help, listening visits, or brief psychological treatment (NCCMH, 2007). Among women who do not meet diagnostic criteria for mental disorder but have elevated depression and/or anxiety symptoms, brief psychological interventions are recommended for those with a previous episode or depression and/or anxiety, whereas social support-based interventions are recommended for those without (NCCMH, 2007). Given the potential risks of medication during pregnancy, psychological therapies are promoted and with a lower threshold for access than in the general population, with guidelines recommending that treatment begin within one month of initial assessment (NCCMH, 2007).

As part of treatment and prevention of mild-moderate disorder, the Whooley questions (Whooley et al., 1997) have been introduced in England and Wales for use at booking and in the postnatal period to identify possible cases of depression, based on current symptoms. The two Whooley questions (a modified version of the PHQ-2; (Kroenke et al., 2003)) are: During

the past month, have you been bothered by: (i) feeling down, depressed or hopeless, (ii) having little interest or pleasure in doing things? (Whooley, et al., 1997). Clinical guidelines (NCCMH, 2007) advise additionally using the Arroll 'help' question: Is this something you feel you need/want help with? (Arroll et al., 2003). The Arroll question is recommended as a way to tackle concerns that the Whooley questions may be over-inclusive, creating unnecessary burden for clinical systems and unnecessary negative impact on women falsely identified as possible cases of depression.

NICE guidelines also recommend detailed assessment and monitoring of women who identified as possible cases of depression using the Whooley and Arroll questions (NCCMH, 2007). However, there is a lack of guidance on how assessment scores map onto eligibility for interventions, or who would undertake further assessment. Additionally, access to psychological therapies is known to be difficult with long waiting lists (Department of Health, 2007); it is therefore questionable how realistic it is that treatment commence within one month of initial assessment, and whether this refers to the initial pre-screen using the Whooley and Arroll questions, or a more detailed assessment using the tools recommended for further assessment.

Little is known about what happens regarding antenatal psychosocial assessment and perinatal mental health pathways in routine clinical practice. We conducted a mixed methods cohort study to investigate: i) the consistency and completeness of mental health assessment documented at hospital booking; ii) the subsequent management of pregnant women identified as experiencing or at risk of mental health problems; and iii) women's experiences of the referral process. The study was part of a wider programme of work, *Assessing and Responding to Maternal Stress* (Darwin, 2012).

Methods

Setting

The research was conducted in a large, inner-city hospital that has approximately 6,000 births per year. The unit cares for women who receive antenatal care in the community from different teams of midwives, depending on their geographical location. Locally, a system is in place to refer women to a team of specialist midwives that specialises in care for women with additional psychosocial concerns; including, mental health, substance use, child protection and asylum seeker or refugee status. Depending on the speciality, these midwives' involvement may be to liaise with or facilitate access to additional services, rather than to provide the clinical care. This is the arrangement for the mental health role which, at the time of the study, reported receiving approximately 200 referrals each year, staffed by one midwife.

Procedure

The study received favourable ethical opinion from the Greater Manchester East Research Ethics Committee (10/H1013/12). Women were sent information about the study with their appointment letter and were invited to take part at their booking visit. The researcher was based in the antenatal clinic to provide information about the study and answer any questions relating to taking part. Inclusion was limited to those women able to provide written consent and complete English-language questionnaires unassisted. Inclusion was not restricted by obstetric factors (e.g. parity) or by type of care (consultant or midwifery-led).

Women (n=191) self-completed both the routine mental health assessment documented in the clinical handheld maternity notes, and a research questionnaire pack. The maternity notes included the Whooley questions (Whooley et al., 1997) and Arroll 'help' question (Arroll et al., 2003). The research questionnaire pack included several measures of 'maternal stress' (i.e. psychological distress and psychosocial risk factors for perinatal mental health) which were used to identify a purposive sub-sample of women (n=22) for interview, as described in detail elsewhere (Darwin et al., 2013).

Clinical and demographic details including mental health assessment and referrals to relevant services were obtained from participants' hospital health records, following birth. The health records contained four sources of information on current and past mental health history: the woman's self-reported history in the handheld notes, the Whooley and Arroll questions in the handheld notes, the GP referral letter (sent when requesting antenatal care for their patient), and the main hospital maternity notes completed by the midwife at booking. Data regarding mental health assessment was extracted from all of these sources.

Longitudinal semi-structured interviews were conducted up to three times during pregnancy and the postnatal period. Interviews were held in the woman's home or the hospital research suite, according to preference. Following informed consent, interviews were audio-recorded and transcribed verbatim using pseudonyms to ensure anonymity. Data was managed using NVivo and analysed using Framework Analysis (Ritchie and Spencer, 1994). Interviews spanned several aspects of maternal stress (Darwin, 2012); we report here on women's experiences of the mental health referral process.

Results

Response rate

Of the 1161 women who had their first antenatal appointment at the hospital site in the study timeframe, 72.0% (n=836) were approached to participate. Reasons for non-approach were: lack of English literacy lack of time due to competing clinic factors, women's personal circumstances or women having already been invited to take part in other research in the current pregnancy (in line with ethical requirements). Almost one-quarter of women (22.9%); n=191) who were invited to take part returned a research pack, including consent to access health records. Of these, 25.7% (n=49) were eligible to be interviewed; that is, they expressed interest in being interviewed and scored above threshold on at least one measure of maternal stress used in the research questionnaire.

Sample characteristics

As shown in Table 1, women in the full sample were aged between 19 and 46 years at booking (mean 31.1, sd 5.3). Approximately two-thirds were White British (67.9%) and the majority were primiparous (58.1%). Older women and White British women were over-represented in this research sample, compared with the hospital population (mean 24.9 years, sd 7.4; 35.9% White British), according to local maternity data provided by the hospital. Women who took part in interviews (n=22) were aged between 26 and 39 years (mean 31.7, sd 4.2). The majority were White British (81.8%) and multiparous (59.1%). Within the interview subsample, gestational age was 10–22 weeks at time 1 (mean 16, sd 2.8) and 28–36 weeks at time 2 (mean 33, sd 1.7). Postnatal interviews (time 3) occurred 7-13 weeks following labour and birth (mean 10, sd 1.4).

Consistency and completeness in the recording of mental health assessment in health records

Completion of the Whooley and Arroll questions and management of responses

Documentation of the Whooley and Arroll responses was limited to the handheld maternity notes, as the main hospital maternity notes did not have any record of these responses.

Consequently these data were only available for the 167 participants whose handheld maternity notes were present in their health records (as shown in Figure 1). Five of these had not completed the questions. Thirty (18.5%) of the remaining 162 women had endorsed at least one of the two Whooley items. Six also endorsed the Arroll item, reporting wanting or needing extra support; the item was uncompleted by a further three women; including one who had not completed the second Whooley question.

[Figure 1 about here]

It is recommended that both the Whooley and Arroll questions should be completed in the first, second and third trimesters, and the corresponding tick boxes are provided in the handheld notes. We found that the questions were only completed at booking, with the exception of one set of notes, where they had been completed in both the first and second trimesters.

Records were checked for any comments documented by a health professional (usually the midwife conducting the booking visit) that indicated discussion of the Whooley responses. Comments were documented for 21 of the 30 women, of which only eight had consistency between the handheld notes and main hospital antenatal notes. There was evidence in 11 cases of midwives having appropriately explored other factors indicating that the symptoms were not indicative of mental health per se (pregnancy-related somatic symptoms e.g. nausea,

backache (n=2); reaction to pregnancy, including previous perinatal loss (n=3); family illness/carer roles (n=3); work/housing (n=2); 'no concerns' (n=1)). Critically, documentation indicating discussion was present for all six women who had endorsed the Arroll 'help' question. Of those six, three were referred to the Mental Health Specialist Midwife (although all were subsequently considered to not meet the local criteria for receipt of additional support). The remaining three included one woman wanting help concerning hyperemesis gravidarum. Another woman had carer roles and was 'struggling' but 'declined referral to social services for extra support'. The final woman was described as 'wanting counselling' and was 'advised to see GP and given leaflet on counselling'. For the three women who had not completed the Arroll item following a positive response to the Whooley items, two were referred to the Mental Health Specialist Midwife and nothing was documented for the third.

Documentation of mental health history in GP referral letters and main hospital maternity notes

A past mental health history was documented for 28 of the 191 women. The booking midwife had documented the majority of cases noted by the GP (14/15). Eight of these women had also self-disclosed on the handheld notes, indicating that GP letters identified seven women who may not have otherwise been identified through the woman's self-report. Midwives documented histories for an additional 12 women who had not been identified by GP correspondence. Of these, nine had disclosed a mental health history in the handheld notes, indicating that the remaining three were identified through further discussion between the midwife and woman. One woman disclosed a mental health history on the handheld notes which was not documented by her booking. The GP letter was also missing from the health records, meaning that the handheld notes provided the only record of this woman's history.

Ten women had been taking prescribed mental health medication at the time of conception; four of which ceased prior to booking. Medication histories were documented in eight of the nine GP letters present; the other GP simply documented 'history of postnatal depression'. Only five of the histories of mental health medication were documented in the handheld notes whereas all ten were reported in the main hospital maternity notes and were referred to the Mental Health Specialist Midwife.

Previous mental health treatment was documented for 25 women. Sixteen reported previous pharmacological interventions, five reported previous psychological interventions (e.g. counselling, cognitive behavioural therapy) and four reported both. The majority of these details were documented in the main hospital maternity notes; in contrast, only four were documented in the handheld notes (two reporting pharmacological and two reporting both pharmacological and psychological; handheld notes were unavailable for six of the 25 women). Treatment history was unknown for the woman whose mental health history was documented only in the handheld notes.

Management of women identified as possible cases and/or disclosing mental health history
Twenty-three women were referred to the Mental Health specialist midwifery service at booking, all of whom had mental health histories documented; predominantly past or current depression or postnatal depression. Five women with mental health histories were not referred, including three where there was evidence of clinical judgement and the booking midwife documented that there were no current mental health concerns.

Handheld notes were available for 20 of the 23 women referred. Ten of the 20 women had endorsed at least one Whooley item; of these, three had endorsed the Arroll 'help' item and

two had not completed it. Reference to current symptoms was made in 11 of the 23 referrals; eight of these women had endorsed at least one Whooley item. No referral made explicit reference to the Whooley questions. Wanting support was documented in nine referrals; of these, three women had endorsed the Arroll item.

The Mental Health Specialist Midwife's response to the 23 referrals were 'will contact patient' (n=3) and 'does not meet criteria' or 'no plans to contact' (n=12). Six of these responses included the instruction that antenatal clinic staff advise the woman to refer herself to her GP if any concerns. There was no evidence of response to eight of the referrals.

Among women deemed ineligible for the service were: women currently taking mental health medication, women with past and continuing postnatal depression, women with past and continuing anxiety, and women with psychological distress symptoms combined with other difficulties (e.g. 'unwanted pregnancy', 'eating problems', 'carer roles', 'lack of support').

Women's experiences of the mental health referral process

Of the 22 women interviewed, six had been referred to the Mental Health Specialist Midwife. These women were all positive about the referral system, feeling this was 'protective' and offered a 'safety net', should it be necessary.

“She [booking midwife] was really, really good and she said, “well, it’s up to you but I can, sort of, give your name to the”...I don’t know what they call it, the midwife who has, sort of, psychiatry training as well, or whatever, “just so they’re aware of it, just in case”” (Jess, time 1)

“They’ve put a sort of, protective referral in, just in case. ... I think it's a really good thing that the mechanism is there for me to be seen really quickly if I start to kind of get any symptoms that I'm worried about. So, I think it's better to do that than, you start to feel like you're losing control and you're having to wait weeks and weeks to see somebody. Particularly because we have to be careful about medication and stuff as well.” (Amanda, time 1)

Observations from health records and the later serial interviews indicated however that these were not necessarily accurate perceptions of the referral system. None of the six women referred for further support were contacted by the Specialist Midwifery service or informed of the outcome of their referral, with the exception of one (Grace) who was re-referred by the research team due to disclosure of symptoms and history of severe mental illness, and subsequently received prompt specialist psychiatric support. Grace’s experience highlighted how lack of follow-up made women vulnerable to falling into gaps in care, which could be potentially dangerous because of influencing further disclosures:

“The way I am speaking to you today, I didn’t tell [booking midwife] deeply like this. She said they will refer me [to specialist midwife] who is very good. So I am waiting for her to look after me but they didn’t refer me yet. I didn’t receive any letter.”
(Grace, time 1)

As well as uncertainty about the purpose and implications of the referral, there was uncertainty about timescales and women could be left waiting to hear:

“[booking midwife] did say that I could look at a referral. I don’t know if she’s done that or not done it, or (.)” (Anne, time 1)

Three women were reviewed by an obstetrician regarding their mental health. Only Louise (a multipara) reported knowing the purpose:

“He really took his time to explain things and go through my options [about medication]. (Louise, time 1)”

The other two (both primiparas) seemed less clear of the purpose but were positive nonetheless:

“She just asked me, like, how I was feeling and if I felt that my medication was working ... which I felt quite grateful for and, yeah, they listened to the baby and we got to hear the baby’s heartbeat and stuff ... the appointment was called, like, a mental health review ... She was definitely a doctor, I don’t know. Yeah, I think she was a psychiatrist, I think, I don’t know, to be honest. ... But she wasn’t a midwife, she was a doctor.” (Jess, time 2)

“I did have a couple of consultant appointments which I presume were booked in because of that [referral].” (Amanda, time 3)

With the exception of Grace, who received specialist psychiatric support, none of the women had ongoing monitoring of symptoms in the postnatal period, as described by Amanda who struggled after her child's birth:

“No, I’m really surprised [that the Health Visitor did not ask about mood postnatally] because obviously I’ve got a history of depression and it was only when talking to a friend ... And I was quite low last time I saw her ... and she said, “Are you sure it’s not postnatal depression, has the health visitor spoken to you?” And I said, “No.” I am surprised actually thinking back, especially with the history that nobody was checking.” (Amanda, time 3).

Two of the women shared their experiences of antenatal mental health referrals raised outside maternity services. Both had been referred to local Community Mental Health Teams by their GPs, prior to booking and independently of the referrals raised within maternity services.

Jess had a history of depression since being a teenager; she was signed off sick from work and was taking anti-depressants at the time of conception, awaiting an appointment with the Community Mental Health Team. Her GP had re-referred Jess when the pregnancy was confirmed and although Jess felt that the pregnancy had “sped [the referral] up a bit” it had still taken four months from the point of re-referral; a timescale not consistent with the clinical guidelines.

Helen had a history of postnatal depression following both previous deliveries and a recent history of depression with medication stopped around conception. Despite being referred by her GP to the Community Mental Health Team at seven weeks, Helen still had not been contacted at the time of the postnatal interview, nine months later. This echoed her experience of mental health referrals in her previous pregnancy, where she had an initial

assessment antenatally but the follow-up was not available until several months after delivery, by which time she could not arrange childcare.

“I’ve not chased it up because I don’t feel overly bothered about it and it might have been a case of like last time, by the time we got the referral the baby was like so many months. ... I don’t think they’ve done anything.” (Helen, time 2)

Helen returned to this at time 3, saying:

“You don’t think that you need help but if it’s not pushed at you – well not pushed, but if it’s not kept on top with, you know, by the health professionals that you’re supposed to keep in contact with then it’ll get missed won’t it” (Helen, time 3)

Discussion

Main Findings

This study has highlighted that the documentation of routine mental health assessment was inconsistent and there was a lack of monitoring of symptoms, even for women identified by the Whooley questions as possible cases of depression. A recording of previous mental health history was the common feature of mental health referrals, with little or no reference to current symptoms of distress, as indicated by the Whooley items. It is possible, however, that the Whooley questions offered a communication device or shaped clinical decision-making in ways that were not indicated by documentation.

Although midwives appeared not to raise referrals on the basis of the Whooley questions being endorsed, there was no shortage of referrals for mental health support. Women interviewed generally spoke positively of the assessment and referral process at the initial interview, viewing the process as offering a 'safety net' and opportunity to 'fast track' support should it be needed. Many women who were referred to the specialist midwifery service were subsequently deemed not to meet the local eligibility criteria for specialist midwifery support; the affected women were rarely informed of this decision.

Interpretation

This was a study of actual clinical practice, and its findings reflect the gap between best practice (based on research) and actual practice (the reality on the ground). To understand some of the barriers to implementation, it is important to reflect on the overall context and approach to managing mental health in pregnancy. The wider maternity services systems are over-burdened with workforce problems (Sandall et al., 2011). Locally, the Mental Health specialist midwifery service received numerous referrals and consequently implemented more stringent eligibility criteria than recommend in the NICE guidelines (NCCMH, 2007). While the needs of women with severe mental health histories received timely specialist services, women with mild-moderate disorder were not eligible for the specialist care, due to the limited availability of resources. While this focus on severe mental illness is understandable, it should be stressed that mild-moderate disorder still has the potential to substantially affect the wellbeing of women and their babies. Such women are seen regularly by health professionals but continue to lack an appropriate care pathway.

The GP referral letter and communication between health professionals

The NICE guidelines state that in all communications with maternity services, including the initial referral for antenatal care, information on mental disorder should be included (NCCMH, 2007). Our study indicates that the GP referral letter is an important factor in determining which women are subsequently referred by the booking midwife for specialist support. Coupled with this, we found instances of past mental health history being omitted in the GP referral letter. Additionally, some women were found to have bidirectional referrals between GPs and maternity services, without either following up the provision of care. Fragmentation of services has been identified as a challenge in perinatal mental health (Ramsay et al., 2001) and joint development would help to clarify the remit of maternity services and improve joint working; an area identified as needing improvement (Rothera and Oates, 2011).

Mental health documentation in the handheld maternity notes

The handheld notes can play a vital role in communication between health professionals however over-reliance must be avoided as notes may be misplaced. Additionally, documentation of potentially sensitive information may be of concern for women due to the notes being read by family and friends (Furber et al., 2009). Communication between health professionals can be facilitated through consistent documentation, for example, ensuring that both the handheld notes and main hospital health records contain dedicated sections for documenting responses to the Whooley and Arroll questions. Additional prompts may ensure consistency, for instance documenting the woman's reported origin of mood. In addition, layout may be improved to help ensure that all items are answered and avoid the Arroll question being uncompleted following the endorsement of a Whooley item. Indeed, documentation was generally more consistent where the Arroll 'help' item had been endorsed, indicating that midwives recognise this as a potential red flag.

Communicating with the woman

Alongside addressing communication between care providers, there is a need for improved communication with women to ensure that they have accurate expectations of the referral systems. Women's responses to the Whooley and Arroll questions should be discussed with them. The women who have been referred for support should be given feedback on the outcome of the referral, and provided with updates when facing waiting times for access. Failure to do so could discourage women from making future disclosures. In addition, some of these women had been taking prescribed mental health medication which was ceased due to concerns with using pharmacological interventions during pregnancy, but without actually putting any alternative support in place. Perceiving that a 'protective referral' exists may raise expectations which, if unfulfilled, lead to dissatisfaction with care. Furthermore, whilst an untested 'safety net' may offer reassurance, one which is tested and found not to work may ultimately be harmful.

Provision of resources for perinatal mental health care

Lack of midwives' confidence has been identified as a barrier to midwives assessing perinatal mental health, and one which can be addressed through psychological assessment skills training; however training alone is insufficient because there remain concerns about time constraints and the lack of structured referral pathways (King et al., 2012; Rollans et al., 2013). The development, implementation and evaluation of low-cost accessible resources embedded in such pathways are urgently needed. In addition, we need to reflect on the overall context and approach to assessing and managing mental health in pregnancy if these are to become embedded into practice. Implementation and sustainability requires that the introduced innovation is seen as part of the "core' business and priorities", does not conflict

with other priorities and that staff have a sense of ‘ownership’ (Greenhalgh et al., 2014). The UK Government has announced plans to make specialist mental health midwifery staff available to every maternity service by 2017 (Department of Health, 2013). Consideration is needed as to how the existence of specialist midwifery roles may influence the working of non-specialist midwives and we need to ensure that provision of specialists does not hamper efforts for mental health to be viewed as part of core business; this could be achieved, for example, through involving staff at all levels in the development of the care pathway to ensure recommendations are realistic. This study adds to the emerging literature that illustrates the potential role of audit (Shah et al., 2013), mapping local service delivery and identifying areas of deficiency such as poor communication (Jomeen and Martin, 2014) in developing robust, accessible perinatal mental health services.

Strengths and Limitations

The study was limited to review of health records held at the hospital and other records, such as those held by GPs and community midwives, were not accessed. Nonetheless, women's accounts were consistent with the review of hospital records, indicating mismanagement of mental health needs, and both poor communication with patients and between health professionals.

It is not known how these observations compare with the experiences of similar units elsewhere, as most published work relates to the practice in specialist centres for perinatal mental health research. The findings are taken from one local unit and, within the sample, White British women and older women were over-represented; care must therefore be taken in extending the findings beyond the study.

Conclusion

Mental health assessment was introduced without adequate resources for consistently responding to those women whose needs were identified. Women's psychological distress could be heightened by failing to fulfil their expectations; including through inadequate management of responses to the Whooley questions and women being uninformed of the outcome of their mental health referral. Pursuit of improved identification of women experiencing or at risk of mental health problems needs to be situated within wider care pathways where assessment, subsequent referral and management are addressed.

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References

American College of Obstetricians and Gynecologists. 2006. Psychosocial risk factors: Perinatal screening and intervention. ACOG Committee Opinion Number 343. *Obstetrics and Gynecology* 108, 469-477.

- Arroll, B., Khin, N., Kerse, N. 2003. Screening for depression in primary care with two verbally asked questions: cross sectional study. *British Medical Journal* 327, 1144-1146.
- Beijers, A., Jansen, J., Riksen-Walraven, M., de Weerth, C. 2010. Maternal prenatal anxiety and stress predict infant illnesses and health complaints. *Pediatrics* 126, e401-409.
- Carroll, J. C., Reid, A. J., Biringer, A., Midmer, D., Glazier, R.H., Wilson, L., Permaul, J.A., Pugh, P., Chalmers, B., Seddon, F., Stewart, D.C. 2005. Effectiveness of the antenatal psychosocial health assessment (ALPHA) form in detecting psychosocial concerns: A randomized controlled trial. *Canadian Medical Association Journal* 173, 253-259.
- Darwin, Z. 2012. *Assessing and Responding to Maternal Stress (ARMS): Antenatal Psychosocial Assessment in Research and Practice*. PhD Thesis. University of Manchester, UK.
- Darwin, Z., McGowan, L., Edozien, L.C. 2013. Assessment acting as intervention: findings from a study of perinatal psychosocial assessment. *Journal of Reproductive and Infant Psychology* 31(5), 500-511.
- Department of Health. 2007. *Commissioning a brighter future: Improving Access to Psychological Therapies - Positive Practice guide*. London, Department of Health.
- Fontein-Kuipers, Y. J., Nieuwenhuijze, M. J., Ausems, M., Bude, L., de Vries, R. 2014. Antenatal interventions to reduce maternal distress: a systematic review and meta-analysis of randomised trials. *British Journal of Obstetrics and Gynaecology* 121, 389-397.
- Furber, C. M., Garrod, D., Maloney, E., Lovell, K., McGowan, L. 2009. A qualitative study of mild to moderate psychological distress during pregnancy. *International Journal of Nursing Studies* 46, 669-677.

Greenhalgh, T., Robert, G., Bate, P., Kyriakidou, O., Macfarlane, F., Peacock, R. 2004. How to Spread Good Ideas. London, National Co-ordinating Centre for NHS Service Delivery and Organisation.

Johnson, R.C., Slade, P. 2003. Obstetric complications and anxiety during pregnancy: Is there a relationship? *Journal of Psychosomatic Obstetrics and Gynaecology* 24, 1-14.

Jomeen, J., Martin, C. R. 2014. Developing specialist perinatal mental health services. *The Practising Midwife* March, 18-21.

King, L., Pestell, S., Farrar, S., North, N., Brunt, C. 2012. Screening for antenatal psychological distress. *British Journal of Midwifery* 20, 396-401.

Kroenke, K., Spitzer, R. L., Williams, J. B. W. 2003. The Patient Health Questionnaire-2: Validity of a two-item depression screener. *Medical Care* 41, 1284-1292.

National Collaborating Centre for Mental Health. (NCCMW) 2007. Antenatal and postnatal mental health. The NICE guideline on clinical management and service guidance. Leicester, The British Psychological Society and The Royal College of Psychiatrists.

Ramsay, R., Welch, S., Youard, E. 2001. Needs of women patients with mental illness. *Advances in Psychiatric Treatment* 7, 85-92.

Ritchie, J., Spencer, L. 1994. Qualitative data analysis for applied policy research. In A. Bryman & R. Burgess (Eds.), *Analysing qualitative data*. (pp. 173-194). London, Routledge.

Rollans, M., Schmied, V., Kemp, L., Meade, T. 2013. 'We just ask some questions...' the process of antenatal psychosocial assessment by midwives. *Midwifery* 29, 935-942.

Rothera, I., Oates, M. 2011. Managing perinatal mental health: A survey of practitioners' views. *British Journal of Midwifery* 19, 304-313.

Sandall, J., Homer, C., Sadler, E., Rudisill, C., Bourgeault, I., Bewley, S., Nelson, P., Cowie, L., Cooper, C., Curry, N. 2011. Staffing in maternity units: Getting the right people in the right place at the right time. London, King's Fund.

Scottish Intercollegiate Guidelines Network (SIGN). 2012. Management of perinatal mood disorders. Edinburgh, SIGN.

Shah, N., Donaldson, L., Giridhar, R. 2013. Completing the cycle: The use of audit to develop a mental health service in times of austerity. *Obstetric Medicine* 6, 165-168.

Talge, N. M., Neal, C., Glover, V. 2007. Antenatal maternal stress and long-term effects on child neurodevelopment: How and why? *Journal of Child Psychology and Psychiatry* 48, 245-261.

Van den Bergh, B. R. H., Mulder, E. J. H., Mennes, M., Glover, V. 2005. Antenatal maternal anxiety and stress and the neurobehavioural development of the fetus and child: Links and possible mechanisms. A review. *Neuroscience and Biobehavioral Reviews* 29, 237-258.

Whooley, M. A., Avins, A. L., Miranda, J. 1997. Case-finding instruments for depression. Two questions are as good as many. *Journal of General Internal Medicine* 12, 439-445.

Table 1 Sample characteristics (n=191)

Characteristic	N (%) or mean/sd (range)
Maternal age at booking (years)	mean 31.1 sd 5.3 (19-46)
Ethnicity	129 (67.9%) White British
Country of birth	141 (73.8%) UK
In a relationship	174 (91.1%)
Primigravida	71 (37.2%)
Nullipara	111 (58.1%)
Midwifery led care	121 (63.4%)
Gestation at booking (weeks)	mean 13 sd 5.4 (8-38)
	144 (75.4%) 1st trimester

Figure 1 Documentation available and its completion

