Primary Health Care Research and Development 2006; **7**: 257–268

Antenatal depression: mothers' awareness and professional responses

Nicky Stanley University of Central Lancashire, Preston, UK, **Rachel Borthwick** Acton Shapiro, Malton, York, UK and **Annie Macleod** Hull and East Yorkshire Primary and Secondary Care Trusts, Hull, UK

Increasingly, attention is shifting away from a focus on postnatal depression to the recognition that depression may be a recurrent experience in many women's lives with the perinatal period constituting a time of particular vulnerability. This article reports on a study undertaken in one primary care trust which explored mothers' and practitioners' experience and awareness of antenatal depression and considered the service response offered by midwives and health visitors. The mothers who participated in focus groups felt ill prepared for the possibility that depression could occur during pregnancy. They identified social and role expectations as well as professional attitudes and service delivery models as barriers to disclosing feelings of depression during this period. The midwives and community nurses surveyed placed rather less emphasis than mothers on the value of continuity of care in pregnancy in promoting disclosure of mental health problems. Community midwives appeared less confident than health visitors in detecting and responding to antenatal depression but both groups of professionals had little knowledge of relevant community services. Co-ordination between midwives and health visitors appeared limited and contact with mental health services was lower than might have been anticipated; the general practitioner (GP) was still seen as the key resource in cases of antenatal depression. However, many of the mothers participating in the study found GPs unresponsive to expressions of negative feelings in pregnancy. The article considers approaches for increasing awareness and detection of antenatal depression and improving co-ordination between services.

Key words: antenatal depression; health visitors; midwives; mothers' mental health; perinatal mental health

Received: January 2005; accepted: March 2006

Whilst awareness of postnatal depression and its symptoms is high amongst both the general public and health professionals, recognition of antenatal depression is much more limited and services are still in the early stages of developing systems to identify and respond to this phenomenon. However, two sources of evidence have been crucial in shifting a focus onto depression in the antenatal period. Evans *et al.*'s (2001) study of depression in women enrolled in the Avon longitudinal study found that depressive symptoms were significantly more prevalent at 32 weeks gestation than at 8 weeks postpartum, a trend already identified by other studies (Green and Murray, 1994; Levy and Kline, 1994; Hayes *et al.*, 2001). The Confidential Enquiry into Maternal Deaths (National Institute for Clinical Excellence, 2001; Lewis and Drife, 2004) has also highlighted the risks of mental illness in the antenatal period: mental illness has emerged as the most common cause of death in the cases studied by the enquiry. These findings have served to identify the antenatal period as a time when vulnerability to mental health problems may be high and have suggested that postnatal depression could be reconceptualized as one manifestation of the mental health problems associated

Address for correspondence: Nicky Stanley, Professor of Social Work, University of Central Lancashire, Preston PR1 2HE, UK. Email: NStanley@uclan.ac.uk

10.1191/1463423606pc295oa
https://doi.org/10.1191/1463423606pc295oa Published online by Cambridge University Press

with the experiences of giving birth and assuming maternal role and identity rather than being viewed as a discrete phenomenon.

A range of risk factors have been identified as relevant to the phenomenon of antenatal depression, including lack of a cohabiting partner (Hobfall *et al*., 1995); marital conflict (Johanson *et al*., 2000); unemployment and lack of qualifications (Bolton *et al*., 1998); previous depression (Spinelli, 1997) unplanned/unwanted pregnancy and native language other than that of country of residence (Rubertsson *et al*., 2003). In common with studies of depression in women generally (Brown and Harris, 1978; Brown *et al*., 1994; Targosz *et al*., 2003) most of these factors can be grouped under the headings of stressful life events and lack of social and family support. However, much of the interest in antenatal depression to date has centred less on its relation to other experiences of depression occurring throughout women's lives and more on the extent to which it can be used to predict the likelihood of postnatal depression (Josefsson *et al*., 2001; Austin and Lumley, 2003; National Institute for Clinical Excellence, 2003) in the UK.

The National Health Service (NHS) Plan (Department of Health, 2000) identified mental health services for women as an area of clinical priority and the consultation paper on the strategic development of mental health services for women (Department of Health, 2002) proposed the development of local specialist perinatal mental health services. However, a recent survey (Oluwatayo and Friedman, 2005) suggests that progress towards this goal has been slow. The implementation guidance for the Women's Mental Health Strategy (Department of Health, 2003) emphasized the need for early detection of mental health problems both antenatally and postnatally, and highlighted the key roles of midwives and health visitors in this area. However, Tully *et al*.'s (2002) study of 182 maternity units in England and Wales found that only 36 per cent had policies relating to the management of women suffering psychological distress during the antenatal period. They discovered that screening for depressive symptoms often did not take place antenatally and this may reflect a lack of awareness concerning the likelihood of depression in this period. The on-going debate around the use of the Edinburgh Postnatal Depression Scale (EPDS) (Leverton and Elliott, 2000; Adams, 2002) which has not been recommended for routine use nationally by the National Screening Committee may also have contributed to this finding. NICE guidelines (National Institute for Clinical Excellence, 2003) specifically advise against the use of routine screening for depression in the antenatal period on the grounds that its efficacy has not been established.

Some of the questions raised by the critics of the EPDS are relevant to consider when seeking to construct an appropriate response to the issue of antenatal depression. Screening or assessment tools can become an end in themselves if used without reflection (Stanley, 1999; Horwath, 2002). Scales may be administered incorrectly or without a clear course of action to follow if depression is suspected (Elliott, 1994; Cox and Holden, 2003). Indeed, anxiety about the capacity to offer a meaningful and resourced response to mental health problems can restrict professionals' capacity to identify psychological distress for fear of 'uncovering something they cannot handle'. However, more positively, screening tools can serve to alert practitioners to indicators of need and can encourage a focus on psychological as well as physical health needs in pregnancy (Clark, 2000).

In England and Wales, *The National Service Framework for Children, Young People and Maternity Services* (Department for Education and Skills and Department of Health, 2004) acknowledges that mental health problems are common in the perinatal period but makes no specific reference to antenatal depression. Indeed, the framework is somewhat vague about the nature of mental health needs during pregnancy and reflects the current emphasis on postnatal mental health by focusing on postnatal depression and puerperal psychosis. Maternity care providers and primary care trusts (PCTs) are to ensure that obstetricians and midwives are able to elicit histories of previous psychiatric disorder early in pregnancy and can provide information on mental health in pregnancy which might promote disclosure of problems. The National Framework advocates the use of care pathways in maternity services and suggests the use of link workers but does not comment specifically on the need for liaison between midwives, health visitors and mental health professionals in relation to women's mental health needs. However, in Scotland, the Framework for Mental Health Services (Scottish Office, 1997) proposed that care pathways might be used as a means of co-ordinating mental health

https://doi.org/10.1191/1463423606pc295oa Published online by Cambridge University Press

services for mothers with postnatal depression and some models have been developed: Glasgow boasts such a system based around a perinatal unit at Gartnaval Hospital (Cantwell, 2003).

The research described here was undertaken within the boundaries of one PCT and was designed as a pilot study for a larger scale investigation. The aim was to explore mothers' knowledge and understandings of antenatal depression as well as that of professionals since it was considered that mothers' difficulties in acknowledging and naming this form of distress might be matched by low levels of awareness amongst practitioners. Mothers' views on what services and forms of support might be most accessible and useful for those experiencing antenatal depression were also captured and were compared with the range of referral routes and support services utilized by professionals. As well as exploring health practitioners' awareness and experience in relation to antenatal depression, the study sought to establish the level of communication and co-ordination between community midwives and health visitors in the area regarding the mental health needs of pregnant women.

Methodology

Mothers' views were collected through a series of four focus groups, which ranged in size from three to ten mothers and their babies. Women were recruited through a variety of agencies including antenatal clinics, Sure Start projects and the local branch of the National Childbirth Trust (NCT). Existing groups were used for the research to take advantage of established patterns of disclosure and discussion within the groups and to benefit from familiar venues which were mother and baby friendly. The 28 women who participated were recruited on the basis that their youngest child was under two. It was considered that this would allow women to comment on the experience of pregnancy from a 'middle distance' when the experience could still be retrieved and described in some detail, but when any mental health problems experienced in pregnancy were less likely to be immediate or 'live'. Women participating in the groups could therefore be expected to exert some control in choosing to share or withhold experiences in a group setting. The focus groups were taped, transcribed and analysed thematically.

The second stage of the study involved a postal survey of all community midwives and health visitors in the PCT. Data from the focus groups were used to inform the design of the questionnaire which covered knowledge of depression in the antenatal period, use of screening tools, referral routes, views concerning relevant resources and the level of communication between midwives and health visitors in cases of antenatal depression. Thirty-nine responses were received from a potential 47 in the area, representing an 83 per cent response rate.

The project was approved by the local NHS Ethics Committee and an advisory group which included local health professionals and a mother who had experienced depression antenatally, provided guidance and consultation on the design and progress of the study. All focus group members gave written consent for the groups to be taped and transcribed and the anonymity of all those who participated in the research has been protected.

Mothers' views

Conceptualizing antenatal depression

The women described experiencing a mixture of emotions in pregnancy and being unprepared for the rapid swings in mood they encountered:

> 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.
>
> (Focus Group 4)

This lack of preparation for the emotional and psychological experience of pregnancy was a common theme. Women described themselves as lacking a frame of reference for their feelings and moods in pregnancy and they were likely to assume that other women were finding pregnancy easier than they were:

> … 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.
>
> (Focus Group 1)

https://doi.org/10.1191/1463423606pc295oa Published online by Cambridge University Press

Many women did not associate depression with the antenatal period:

> I've never even heard of antenatal depression …
>
> (Focus Group 2)

> 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.
>
> (Focus Group 4)

Shame about not living up to common expectations of pregnancy as a 'happy and blooming' experience could function as a barrier to disclosing negative feelings:

> I think if I had had any of those feelings, I wouldn't have told anybody, I would have kept them to myself … Because … they're not normal feelings and it's not how you're supposed to feel when you're pregnant.
>
> (Focus Group 4)

However, a small number of focus group participants did identify themselves as having experienced antenatal depression. The mother quoted below described severe feelings of depression during pregnancy which persisted after the birth:

> 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.
>
> (Focus Group 1)

Pregnancy was identified by a number of women as a time of transformation in relation to both the body and social roles:

> 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 …
>
> (Focus Group 2)

> … I think other people's attitudes change towards you.
>
> (Focus Group 1)

These role shifts could be a source of considerable anxiety:

> I thought I'd be the world's worst mum, you know get everything wrong.
>
> (Focus Group 1)

> 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.
>
> (Focus Group 3)

Difficulties in social and personal circumstances and unplanned pregnancies in particular were identified as additional sources of shock and distress:

> 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.
>
> (Focus Group 2)

Accessing support

Most women felt that in the first instance they would turn to their partner, family or friends for support in coping with depression during pregnancy. In common with Brown *et al.*'s (1986) findings on depression in women, mothers were frequently cited as important confidantes, although they could also be judgmental:

> I did get quite depressed with the first baby and I got my Mum straight away. Mum came down and I talked it through with her and discovered that she felt the same.
>
> (Focus Group 2)

https://doi.org/10.1191/1463423606pc295oa Published online by Cambridge University Press

> … 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.
> (Focus Group 1)

Friends who were also pregnant could be an important source of informal support and positive ratings of antenatal classes were linked to the opportunities they provided for meeting other women in the same position. However, other people could find it hard to engage with the expectant woman's perspective:

> And when I actually expressed my feelings to [friends], 'oh, don't worry about it.'
> (Focus Group 1)

Similarly, some professionals, particularly doctors, were perceived as dismissive of attempts to communicate difficulties in pregnancy:

> And I did actually mention something and my doctors were actually no use, they just turn around and said, 'oh well, it's the weather'.
> (Focus Group 1)

The attitudes of health professionals could provoke feelings of guilt or shame in women who were seeking to disclose emotional difficulties. General practitioners (GPs) came in for some particularly heavy criticisms:

> … 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 …
> (Focus Group 4)

> 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.
> (Focus Group 1)

However, professionals who did offer emotional support and provided opportunities to vent distressing feelings were able to impact on women's sense of being isolated by their 'inappropriately' negative feelings during pregnancy:

> They made me feel, they made me realise I wasn't on my own, that, all stuff that could be done …
> (Focus Group 1)

> … 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.
> (Focus Group 2)

Opportunities to disclose negative experiences and emotions were considered most likely to occur in the context of a relationship with a professional that was continuous through the pregnancy:

> … 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 …
> (Focus Group 2)

However, women also considered that continuity of care which encouraged the disclosure of distress could be provided by a small group of midwives who worked as a close team:

> 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.
> (Focus Group 2)

Women also emphasized the importance of being given time and space to talk about feelings with those responsible for their antenatal care. A preoccupation with checks and procedures in clinical settings was often experienced as a barrier to open communication with health professionals:

> 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.
> (Focus Group 2)

Those women who had received antenatal care from Sure Start midwives were more likely to have encountered those service features which they considered promoted disclosure. Sure Start staff who held limited caseloads were described as more available to offer women opportunities to form supportive relationships. Generally, the women who

https://doi.org/10.1191/1463423606pc295oa Published online by Cambridge University Press

had received their antenatal care from Sure Start projects were satisfied with their care, while the responses of those using other forms of care were more mixed.

The professionals' perspectives

Levels of relevant experience and contact

Twenty-four health visitors, 14 community midwives and 1 health practitioner responded to the survey. Over a quarter (10) of the 39 respondents were located in Sure Start settings, since this PCT covered a number of Sure Start projects, reflecting the high levels of social exclusion in the locality. The respondents were generally an experienced group with nearly half having worked for more than five years in their current field of practice; all but two (one did not specify) were female. As Table 1 shows, nearly three-quarters (29) of the practitioners reported working with at least one woman whom they considered had been suffering from antenatal depression in the past two years; this group included 12 of the 14 midwives participating in the study. About half the respondents reported working with more than five women who were antenatally depressed in the same period. Seven respondents described being involved in the care of at least 10 women with antenatal depression in the past two years: six of these were Sure Start staff.

Most of the practitioners (30) surveyed saw the community midwife as the lead professional for antenatal care. The community midwife was also most likely to be considered the professional best equipped to identify antenatal depression. While nearly all the 14 midwives reported seeing women three or more times during pregnancy, Sure Start staff were likely to see women more frequently on an informal basis. Most of the health visitors only saw women once during pregnancy and five never saw women prior to the birth. Those health visitors (2) who saw women more often in pregnancy did so in the context of working alongside GPs in antenatal clinics.

However, frequency of contact with midwives did not entail consistency of service. As Table 2 shows, only a third of the respondents thought that women were able to receive all their antenatal care from one midwife in the PCT with over half reporting that this was never or rarely the case. In line with the views of the mothers reported above, some respondents described working in small teams where they felt that good communication ensured that a degree of consistency was offered:

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

Table 1 Practitioners' perceptions of numbers of women with antenatal depression worked with within past two years

	Midwives	HVs	All respondents
None	1	2	3(8%)
1–10	8	14	22(56%)
More than 10	4	3	7(18%)
Do not know/ No response	1	6	7(18%)
Total	14	25	39(100%)

Table 2 Availability of continuity of antenatal care from just one midwife

	Number of respondents	% of respondents
Never	3	8
Rarely	19	48
Sometimes	10	26
Often	3	8
Do not know	4	10
Total	39	100

Awareness of and screening for antenatal depression

The mothers who participated in the focus groups expressed uncertainty about which feelings and psychological states were considered 'normal' in pregnancy. It seemed likely that professionals might share this uncertainty as antenatal depression is not widely recognized. Practitioners' capacity to distinguish between expressions of anxiety and trepidation which might be considered within the 'normal' range and those which might warrant concern was examined by asking them to rate a series

https://doi.org/10.1191/1463423606pc295oa Published online by Cambridge University Press

Table 3 Social and emotional factors routinely raised by practitioners in antenatal care

Factor mentioned	Number of times listed
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 vignettes using a Likert-type scale. These were informed by data gathered from the focus group interviews in conjunction with literature focusing on women's experience of perinatal depression and were piloted with a number of professionals before use. The group displayed varying degrees of awareness in relation to expressions of high levels of distress; less than half of those who responded recognized those statements designed to convey abnormal feelings. Health visitors were rather more likely to do so than midwives, perhaps reflecting their familiarity with screening for postnatal depression.

Again, less than half those surveyed reported that they used a screening tool for depression during pregnancy. The four midwives who did use the EPDS antenatally were all based in Sure Start settings. In order to discover whether checking for indicators of need was integrated into their practice rather than achieved through the use of a particular tool, practitioners were asked which social and emotional factors they routinely discussed as part of antenatal care. Table 3 shows that 'sensitive 'issues such as a woman's mental health history, experience of domestic violence or drug use were much less likely to be raised than questions which focused on family, partner, social or economic support. Only 10 of the practitioners surveyed described routinely asking mothers whether the pregnancy was planned or they were happy about it; in contrast, the mothers who participated in the focus groups identified the issue of whether a pregnancy was planned or wanted as key in achieving satisfactory adjustment to the changes experienced in pregnancy.

Co-ordination and collaboration

Referral to the GP was the most common response to antenatal depression reported by the practitioners with 32 of the 39 respondents and all but one of the midwives envisaging this course of action. However, in common with the health visitors who participated in Jeyarajah, Dent and McIntyre's (2000) study, some respondents were dissatisfied with the quality of the response obtained from GPs. One midwife commented:

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

Just under half the group indicated that they would liaise with community mental health services in cases of suspected antenatal depression and a similar proportion reported doing so in practice. Midwives appeared more likely as a group than health visitors to take this approach. Again, it appeared that the response from other services could be disappointing with practitioners finding that women they referred often did not meet the criteria for receiving a service:

> CMHT [Community Mental Health Team] don't often respond – not severe and enduring …
>
> (Community Midwife)

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. The PCT covered by the study reported here included specialist mother and baby link practitioners in the community mental health teams, but only five respondents saw them as a potential resource for cases of antenatal depression.

Communication between midwives and health visitors in cases of antenatal depression was not as high as might have been anticipated with less than half (6) of the midwives indicating that they would discuss the issue with health visitors and about two-thirds (16) of the health visitors saying that they would do so. However, communication was found at higher levels in both professional groups when those who had actually worked with cases of

https://doi.org/10.1191/1463423606pc295oa Published online by Cambridge University Press

antenatal depression described their practice. When liaison with other professionals did take place, the outcome was usually described as additional support for the woman or an increased number of visits. While the practitioners themselves were likely to provide what some described as extra 'listening visits' in cases of suspected antenatal depression, collaboration with other professionals could also result in additional joint visits.

Resource awareness and perceived need

The practitioners' awareness of local services for women experiencing antenatal depression was limited with over half (21) failing to identify any services. Those who did suggest relevant services were likely to focus on community mental health teams or Sure Start. There was little mention of voluntary sector services such as MIND or Women's Centres. In common with the mothers who participated in the focus groups, a third of the practitioners considered that they themselves would need to spend more time with mothers in order to detect and respond to antenatal depression. However, only five practitioners considered continuity of care to be a necessary component in developing a more effective approach.

In identifying resources which would be valuable in responding to antenatal depression, a third of the group specified a need for a routine screening tool to assess mental health in pregnancy. However, there was no consensus as to which tool might be used or when it might be used in pregnancy. Tully *et al*. (2002) found that those maternity units which did undertake screening for antenatal depression were likely to do so at the booking-in point which failed to take account of changes which might occur in the later stages of pregnancy. Clear referral routes or pathways were also mentioned by a third of the practitioners responding to the survey and this approach is advocated in government guidance as a means of achieving co-ordination between relevant services. There was also some enthusiasm for a specialist team or for individual professionals, whether those involved in community health and maternity services or those employed by mental health services, to develop expertise and skills in this area which could be shared with others.

Discussion

While this was a small local study which could usefully be replicated on a larger scale, the findings suggest that both the general public and primary care practitioners might benefit from more information about the nature and likelihood of antenatal depression. Women are required to make substantial psychological and social adjustments in pregnancy and, for a number of the women who participated in the focus groups, the extent of these adjustments seemed to have been unanticipated, particularly in first pregnancies. From the mothers' perspectives, the possibility of pregnancy being a period when distress might be encountered appeared to be rarely acknowledged in either professional or public discourses. Those women who reported good experiences of antenatal care emphasized a sense of being informed and well prepared and preparation needs to embrace the potential for negative as well as positive emotional experiences.

Shifts in professionals' awareness of and sensitivity to antenatal depression are essential if mothers are to feel more ready to disclose distress and seek help. Stewart and Henshaw's (2002) survey found that midwives acknowledged the need to develop their knowledge of perinatal mental health. Although the midwives contributing to the study reported here described considerable experience of encountering antenatal depression, their sensitivity to its manifestations appeared slightly less developed than that of the health visitors who were more likely to be involved in screening for postnatal depression. One of the arguments for the use of screening tools is their capacity for raising practitioners' awareness of particular health needs and their manifestations. The accounts of the mothers participating in the study suggest that GPs may be another group who are particularly in need of training and information in relation to antenatal depression.

Both practitioners and mothers contributing to this study acknowledged the need for professionals to spend additional time with mothers if feelings of distress and depression were to be elicited. Mothers were more likely to emphasize continuity of care in pregnancy than professionals who acknowledged that it was rarely available locally. However, mothers were also able to identify the benefits of receiving antenatal care from an integrated team of midwives. The Sure Start model

https://doi.org/10.1191/1463423606pc295oa Published online by Cambridge University Press

with its emphasis on non-judgmental responses to mothers delivered in non-clinical settings, together with staff's limited caseloads and consequent flexibility appeared to increase staff's perceived availability and accessibility. However, despite the government's plans for mainstreaming Sure Start, the current picture of limited resources in midwifery services (Nursing Standard, 2005) means that such approaches will need to be targeted on those with the highest levels of need.

Targeting services requires an initial assessment of need. Attempts to validate the EPDS and other screening tools for use in pregnancy as a means of predicting postnatal depression have not been successful (Austin and Lumley, 2003). The EPDS might be used to detect the presence of antenatal depression but questions arise as to when and how often it might be administered in pregnancy. The attribution of numerical scores and the use of cut-off points which are features of the EPDs (and other forms of risk assessment) are also unhelpful in conveying a picture of scientific certainty where little exists (Stanley and Manthorpe, 1997). While screening tools can give practitioners permission to raise sensitive subjects (such as domestic violence which may contribute to the experience of antenatal depression) they can also function as a bureaucratic barrier that impedes the development of a confiding relationship between patient and professional. This study found that, in the absence of any framework for screening or assessment, practitioners routinely asked about a rather limited range of social and emotional factors in the antenatal period: women's mental health histories, their experience of domestic violence and the question of whether the pregnancy was planned were only described as being regularly discussed by about a fifth of the practitioners surveyed.

However, as Stewart and Henshaw (2002, p. 118) note, screening or even raising sensitive questions may represent a 'Pandora's box' for practitioners if they are unaware of appropriate referral routes or relevant services for women with antenatal depression. The practitioners contributing to this local study conveyed a picture of some co-ordination and collaboration between community midwives and health visitors (although not as much as might be anticipated in cases of antenatal depression) and variable levels of communication with community mental health services. Some evidence of midwives' difficulties in accessing mental health services was also found in Tully *et al*.'s (2002) study and these problems appear, at least in part, to be attributable to the high thresholds established for receipt of specialist mental health services: many depressed women fail to meet the service's 'severe and enduring' criteria. The practitioners' knowledge and use of other relevant local resources for women with antenatal depression appeared low. Most of the professionals surveyed still relied heavily on the GP as the key professional to whom they would refer women with antenatal depression or from whom they would seek advice.

Increasing recognition of women's vulnerability to mental health problems in the perinatal period has resulted in the advocacy of care pathways as a model for co-ordinating services (Department of Health, 2002). However, care pathways, while offering a theoretically attractive solution to problems of co-ordinating the input of different services, may prove less effective in practice. Rees *et al*.'s (2004) study of the use of an integrated care pathway (ICP) in community mental health teams in south-west Scotland found that, although practitioners expressed high levels of enthusiasm for the approach, it was not being implemented in practice. Similarly, in the PCT where the study reported here was undertaken, a group of midwives in one area had introduced an ICP which other local practitioners and managers were unaware of. Rees *et al*. (2004) emphasize that ICPs require the support of senior management from all relevant organizations if they are to be successfully implemented. While such agreement may be feasible when mental health and maternity services have already achieved integrated working in the form of a perinatal unit, it may prove harder for community-based services, one of which has a universal remit while the other is highly targeted, to achieve co-ordination at sufficiently high organizational levels.

Questions also need to be asked as to whether ICPs can be sufficiently flexible to respond to mothers' mental health needs which are likely to fluctuate in intensity and duration, requiring on-going monitoring and communication between different services. A more effective approach might be offered by an informed and aware community midwife receiving advice and consultation from a mental health worker who can be 'called in' at times when additional specialized input is required. The Confidential Enquiry into Maternal Deaths (Lewis and Drife, 2004) recommended a co-ordinating role

https://doi.org/10.1191/1463423606pc295oa Published online by Cambridge University Press

for a known midwife in cases where women with mental health problems were receiving care from a number of agencies. The recommendation from the local study (Borthwick *et al*., 2004) reported here was that commissioners should work with the Mental Health Trust to explore the possibility of locating specialist mother and baby community psychiatric nurses (CPNs) within community health teams and Sure Start services.

Conclusion

If the patterns of interprofessional and interagency co-ordination identified by this study are representative of those elsewhere in the UK it would be inappropriate to propose introducing screening programmes for antenatal depression when the service response is so underdeveloped. Such an approach might only contribute to practitioners' fears of opening 'cans of worms' which they lack the resources to manage. However, specialist mental health services and any additional community midwifery services do need to be targeted on those with the highest levels of need. A set of social and psychological indicators might alert midwives to the need for additional support and perhaps referral to specialist service. Such a checklist might usefully cover current mood and symptoms, whether the pregnancy was planned/wanted, mental health history, experience of domestic violence, availability of a confiding relationship, recent stressful life events and refugee or migrant status (Rubertsson *et al*., 2003). This last factor was also identified as relevant by the Confidential Enquiry into Maternal Deaths (Lewis and Drife, 2004) and it would be worth exploring the service response to antenatal mental health problems in some of the metropolitan areas where there are likely to be higher rates of women with English as a second language in need of antenatal care than was the case in the area where this research was undertaken.

In view of the experiences reported by mothers and practitioners in this study, the reliance on the GP as a source of expertise and treatment for antenatal depression is a matter for concern. The House of Commons Health Committee (2003) confirmed this continuing centrality of the GP in maternity services, noting that much care continues to be routed through them. GPs' role in the delivery of mental health care is increasingly coming under scrutiny (The Sainsbury Centre for Mental Health, 2003; Armstrong and Earnshaw, 2005) and additional mental health workers have been introduced into primary health care settings in an attempt to boost performance in this area (Department of Health, 2003). However, sensitivity to the mental health needs of women in pregnancy is an issue which could be addressed by GP training.

Finally, this study emphasizes the need for depression in the antenatal period to be acknowledged as an issue in its own right which requires developed approaches to detection and response. There has been a marked tendency for research and policy to approach depression in the antenatal period predominantly in terms of whether it can function effectively as an indicator for postnatal depression. It may be more helpful to see both forms of depression as responses to the physiological, psychological and role changes associated with childbirth and to recognize that the complexity of these recurrent changes make women particularly vulnerable to depression across their lifetimes.

Acknowledgement

This study was funded and supported by West Hull PCT. The views expressed are the authors' own.

References

Adams, C. 2002: Use of the Edinburgh Postnatal Depression Screening Scale. *Community Practitioner* 75, 142.

Armstrong, D. and **Earnshaw, G.** 2005: A comparison of GPs and nurses in their approach to psychological disturbance in primary care consultations. *Health and Social Care in the Community* 13, 108–11.

Austin, M.-P. and **Lumley, J.** 2003: Antenatal screening for postnatal depression: a systematic review. *Acta Psychiatrica Scandinavica* 107, 10–17.

Bolton, H.L., Hughes, P.M., Turton, P. and **Sedgwick, P.** 1998: Incidence and demographic correlates of depressive symptoms during pregnancy in an inner London population. *Journal of Psychosomatic Obstetrics and Gynaecology* 19, 202–209.

Borthwick, R., Macleod, A. and **Stanley, N.** 2004: *Antenatal depression: developing an effective and co-ordinated service response*. University of Hull.

Brown, G.W., Andrews, B., Harris, T., Adler, Z. and **Bridget, L.** 1986: Social support, self-esteem and depression. *Psychological Medicine* 16, 813–31.

Brown, G.W. and **Harris, T.O.** 1978: *The social origins of depression: a study of psychiatric disorder in women*. London: Tavistock Publications.

Brown, G.W., Harris, T.O., Hepworth, C. and **Robinson, R.** 1994: Clinical and psychosocial origins of chronic depression. 2. A patient enquiry. *British Journal of Psychiatry* 165, 457–65.

Cantwell, R. 2003: Detection and screening in perinatal psychiatry. *Psychiatry* 2, 20–25.

Clark, G. 2000: Discussing emotional health in pregnancy: the Edinburgh Postnatal Depression Scale. *British Journal of Community Nursing* 5, 91–98.

Cox, J. and **Holden, J.** 2003: *Perinatal mental health: a guide to the Edinburgh Postnatal Depression Scale*. London: Gaskell.

Department for Education and Skills and Department of Health. 2004: *The national service framework for children, young people and maternity services*. London: Department of Health.

Department of Health. 2000: *The NHS Plan*. London: The Stationery Office.

Department of Health. 2002: *Women's mental health: into the mainstream, strategic development of mental health care for women*. London: Department of Health.

Department of Health. 2003: *Mainstreaming gender and women's mental health: implementation guidance*. London: Department of Health.

Department of Health and National Institute for Mental Health in England. 2003: *Fast-forwarding primary care mental health, graduate primary care workers – best practice guidance.* London: Department of Health.

Elliott, S.A. 1994: Uses and misuses of the Edinburgh Postnatal Depression Scale in primary care: a comparison of models developed in health visiting. In Cox, J. and Holden, J., editors, *Perinatal psychiatry: use and misuse of the Edinburgh Postnatal Depression Scale*. London: Gaskell, 221–32.

Evans, J., Heron, J., Francomb, H., Oake, S. and **Golding, J.** 2001: Cohort study of depressed mood during pregnancy and after childbirth. *British Medical Journal* 323, 257–60.

Green, J.M. and **Murray, D.** 1994: The use of the Edinburgh Postnatal Depression Scale in research to explore the relationship between antenatal and postnatal dysphoria. In Cox, J. and Holden, J., editors, *Perinatal psychiatry: use and misuse of the Edinburgh Postnatal Depression Scale*. London: Gaskell, 180–98.

Hayes, B.A., Muller, R. and **Bradley, B.S.** 2001: Perinatal depression: a randomized controlled trial of an antenatal education intervention for primiparas. *Birth* 28, 28–35.

Hobfall, S.E., Ritter, C., Lavin, J., Hulsizer, M.R. and **Cameron, R.P.** 1995: Depression prevalence and incidence among inner-city pregnant and postpartum women. *Journal of Consulting and Clinical Psychology* 63, 445–53.

Horwath, J. 2002: Maintaining a focus on the child? *Child Abuse Review* 11, 195–213.

House of Commons Health Committee. 2003: *Choice in maternity services, Ninth Report of Session 2002–03*, Volume 1, HC 796-1. London: The Stationery Office.

Jeyarajah, Dent, R. and **McIntyre, C.** 2000: Health visitors, children and parental mental health problems. In Reder, P., McClure, M and Jolley, A., editors, *Family matters: interfaces between child and adult mental health*. London: Routledge.

Johanson, R., Chapman, G., Murray, D., Johnson, I. and **Cox, J.** 2000: The North Staffordshire Maternity Hospital prospective study of pregnancy-associated depression. *Journal of Psychosomatic Obstetrics and Gynaecology* 21, 93–97.

Josefsson, A., Berg, G., Nordin, C. and **Sydsjo, G.** 2001: Prevalence of depressive symptoms in late pregnancy and postpartum. *Acta Obstetricia et Gynecologica Scandanavica* 80, 251–55.

Leverton, T.J. and **Elliott, S.A.** 2000: Is the EPDS a magic wand? *Journal of Reproductive and Infant Psychology* 18, 278–307.

Levy, V. and **Kline, P.** 1994: Perinatal depression: a factor analysis. *British Journal of Midwifery* 2, 154–59.

Lewis, G. and **Drife, J.** 2004: *Why mothers die 2000–02, the sixth report of the Confidential Enquiries into maternal deaths in the United Kingdom*. London: Royal College of Obstetricians and Gynaecologists.

National Institute for Clinical Excellence. 2001: *The Confidential Enquiries into maternal deaths in the United Kingdom: why mothers die 1997–99*. London: RCOG Press.

National Institute for Clinical Excellence. 2003: *Clinical guideline 6 – antenatal care: routine care for the healthy pregnant woman*. London: National Institute for Clinical Excellence.

Nursing Standard. 2005: Midwife shortage set to last until 2150, 26/1/05, 19, 20, 5.

Oluwatayo, O. and **Friedman, T.** 2005: A survey of specialist perinatal mental health services in England. *Psychiatric Bulletin* 29, 177–79.

Rees, G., Huby, L., McDade, L. and **McKechnie, L.** 2004: Joint working in community mental health teams: implementation of an integrated care pathway. *Health and Social Care in the Community* 12, 527–36.

Rubertsson, C., Waldenström, U. and **Wickberg, B.** 2003: Depressive mood in early pregnancy: prevalence and women at risk in a national Swedish sample. *Journal of Reproductive and Infant Psychology* 21, 113–23.

Scottish Office. 1997: *A framework for mental health services in Scotland*. Edinburgh: Scottish Office.

Spinelli, M.G. 1997: Interpersonal psychotherapy for depressed antepartum women: a pilot study. *American Journal of Psychiatry* 154, 1028–30.

Stanley, N. 1999: User-practitioner transactions in the new culture of community care. *British Journal of Social Work* 29, 417–35.

Stanley, N. and **Manthorpe, J.** 1997: Developing training in risk assessment. *Social Work and Social Sciences Review* 7, 26–38.

Stanley, N., Penhale, B., Riordan, D., Barbour, R.S. and **Holden, S.** 2003: *Child protection and mental health services: interprofessional responses to the needs of mothers.* Bristol: Policy Press.

Stewart, C. and **Henshaw, C.** 2002: Midwives and perinatal mental health. *British Journal of Midwifery* 10, 117–21.

Targosz, S., Bebbington, P., Lewis, G., Brugha, T., Jenkins, R., Farrell, M. and **Meltzer, H.** 2003: Lone mothers, social exclusion and depression. *Psychological Medicine* 233, 715–22.

The Sainsbury Centre for Mental Health. 2003: *Primary solutions: an independent policy review on the development of primary care mental health services*. London: Sainsbury Centre for Mental Health.

Tully, L., Garcia, J., Davidson, L. and **Marchant, S.** 2002: Role of midwives in depression screening. *British Journal of Midwifery* 10, 374–78.

https://doi.org/10.1191/1463423606pc295oa Published online by Cambridge University Press