



‘We just ask some questions...’ the process of antenatal psychosocial assessment by midwives



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ABSTRACT

Objective: this qualitative ethnographic study describes the content and process of psychosocial assessment and depression screening undertaken by midwives in the antenatal booking visit in two maternity units in New South Wales (NSW), Australia.

Study design: participants included 34 pregnant women and 18 midwives who agreed to be observed during the antenatal booking visit. A structured observation tool and field notes were used to record observations of the assessment and screening process including the midwives' approaches (actions and interactions) communication styles, and the interactive dynamics between the midwives and the women. Midwives also participated in a brief interview after the observation.

Findings: midwives varied in their approach to psychosocial assessment. Some followed the structured format tending to deliver the questions in a directive manner, whereas others appeared more flexible in their approach and delivery of sensitive questions. In some instances midwives modified the questions. Modification appeared to occur to assist in the interpretation and comprehension of the questions.

Conclusion: midwives were observed using a range of skills when undertaking psychosocial assessment including empathetic responding, however, modification of questions may reflect a level of discomfort on the part of the midwife in asking sensitive questions and may impact on the integrity of the assessment. Further training and support is required to 'fine tune' the process of assessment and better respond to disclosure of sensitive information.

Implications for practice: midwives require organisational support for ongoing training and clinical supervision to effectively undertake routine psychosocial assessment.

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Introduction

Social and emotional health problems in the perinatal period can lead to poor outcomes for women, their infants and families (Murray et al., 2003; Najman et al., 2005; Priest et al., 2005; Robinson et al., 2011). There are known, identifiable risk factors for poorer maternal and/or infant and child health such as lack of social support, previous or current mental health problems, childhood abuse and domestic violence (Buist et al., 2007). Subsequently, there is an international move to identify women with risk factors for poor perinatal mental health early and offer support and services. This process relies on the effective assessment by

midwives and other primary health-care clinicians of women in pregnancy and after birth (Karatas et al., 2009).

In response, a number of Australian jurisdictions are introducing routine psychosocial assessment. In the state of New South Wales (NSW), the Supporting Families Early policy has already integrated psychosocial risk assessment with routine physical care during pregnancy and following birth, providing a co-ordinated network of support and health-related services for mothers, infants and families (NSW Department of Health, 2009). Accordingly, assessment and screening is conducted by midwives' at the antenatal booking visit and by child and family health nurses (CFHN) at the universal home visit following birth and is then reviewed again at the six to eight week check at the Early Childhood Centre. See the assessment questions included in the psychosocial assessment tool in NSW are presented in Table 1. These questions reflect seven key variables or domains of risk that are to be assessed (NSW Department of Health, 2009). Including

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Table 1
Questions used in psychosocial assessment in NSW.

Variables (risk factors)	Suggested format for psychosocial assessment questions
I. Lack of support	1. Will you be able to get practical support with your baby? 2. Do you have someone you are able to talk to about your feelings or worries?
II. Recent major stressors in the last 12 months	3. Have you had any major stressors, changes or losses recently (i.e., in the last 12 months) such as, financial problems, someone close to you dying, or any other serious worries?
III. Low self-esteem (including lack of self-confidence, high anxiety and perfectionist traits)	4. Generally, do you consider yourself a confident person? 5. Does it worry you a lot if things get messy or out of place?
IV. History of anxiety, depression or other mental health problems	6a. Have you ever felt anxious, miserable, worried or depressed for more than a couple of weeks? 6b. If so, did it seriously interfere with your work and your relationships with friends and family? 7. Are you currently receiving, or have you in the past received treatment for any emotional problems?
V. Couple's relationship problems or dysfunction (if applicable)	8. How would you describe your relationship with your partner? 9a. <i>Antenatal</i> : What do you think your relationship will be like after the birth? OR 9b. <i>Postnatal (in Community Health Setting)</i> : Has your relationship changed since having the baby?
VI. Adverse childhood experiences	10. Now that you are having a child of your own, you may think more about your own childhood and what it was like. As a child were you hurt or abused in any way (physically, emotionally, sexually)?
VII. Domestic violence Questions must be asked only when the woman can be interviewed away from partner or family member over the age of 3 years. Staff must undergo training in screening for domestic violence before administering questions	11. Within the last year have you been hit, slapped, or hurt in other ways by your partner or ex-partner? 12. Are you frightened of your partner or ex-partner? (If the response to questions 11 and 12 is 'No' then offer the DV information card and omit questions 13–18) 13. Are you safe here at home?/to go home when you leave here? 14. Has your child/children been hurt or witnessed violence? 15. Who is/are your children with now? 16. Are they safe? 17. Are you worried about your child/children's safety? 18. Would you like assistance with this? 19. Are there any other issues or worries you would like to mention?
Opportunity to disclose further	

NSW Department of Health, 2009. NSW Health/Families NSW Supporting Families Early Package—SAFE START Strategic Policy. NSW Department of Health, North Sydney.

psychosocial assessment as part of antenatal and postpartum care has been deemed 'good practice' in the national clinical guidelines for perinatal depression and anxiety (Beyondblue, 2011).

There are a number of concerns, however, about the integration of psychosocial assessment into routine clinical care (Matthey et al., 2005), particularly the adequacy of the tools used to screen for depression and to detect psychosocial risk (Yelland et al., 2009). The assessment tool used in NSW is based on two large studies conducted in three sites in NSW, Australia. The first study by Matthey et al. (2004) reported the use of the Antenatal Pregnancy Risk Questionnaire to investigate the presence of psychosocial risk

factors and the impact of these on women's mental health. Women ($n=2173$) attending the antenatal clinic were assessed, representing 97% of all women attending the clinic over a 12 month period. The study reported that face and content validity was evident and that there was an association between the number of risks and the services used. Validity was further suggested through the demonstration of similar proportions of women presenting with a history of anxiety or depression and/or domestic violence as those recorded by other known study populations. Sensitivity, specificity, PPV and NPV were not reported, as women who were classified as 'at risk' from this assessment were then offered an intervention. No reliability data or testing was reported (Johnson et al., in press).

The second study conducted by Austin et al. (2011) tested the Antenatal Risk Assessment Questionnaire (ANRQ). The ANRQ comprises 12 items and is scored using a combination of categorical and continuous data, with a possible maximum score of 62 and minimum score of 5. The receiver operating characteristic (ROC) area under the curve (AUC) was 0.69 at the most clinically relevant cut-off of 23. At this cut-off the sensitivity was 0.62, the specificity was 0.64, the Positive Predictive Value was 0.30 and the Negative Predictive Value was 0.87. The acceptability of the ANRQ was high amongst both pregnant women and midwives (Austin et al., 2011). The findings of both these studies demonstrate that further work is required to establish reliability and validity of routine psychosocial assessment tools (Johnson et al., in press).

Other commentators add that the assessment of social and emotional health needs requires specific skills in understanding, interpreting and responding appropriately to women's needs (Briggs, 2006; McCourt, 2006). Concern has been raised about the approach used by health professionals (Hegarty et al., 2007; Yelland et al., 2009) and particularly the training and skills of midwives and nurses undertaking the assessment (Jomeen et al., 2009; Marron and Maginis, 2009), the support provided to them (Cowley and Houston, 2003) and the possible impact on their well-being (Mollart et al., 2009).

The aim of this paper is to report on the content and process of antenatal psychosocial assessment undertaken by midwives at the booking visit. Specifically, the paper describes the approach (actions and interactions) that midwives take to integrate this assessment into the routine booking visit, the introduction and delivery of the psychosocial questions and how midwives respond to the woman's answers. Data analysed and reported here are part of a larger study that has also examined the approach taken by CFHN to psychosocial assessment after birth.

Methods

This is an ethnographic study that was conducted in NSW, Australia. Data were collected between September 2010 and March 2011 and comprised of observations of the booking visit to describe the content and process of psychosocial assessment and to examine the interaction between midwives and women. Ethics approval for the study was obtained from the Human Research Ethics Committee at both study sites and from the University of Western Sydney.

Study sites

The study was conducted in the antenatal clinic of two tertiary referral metropolitan hospitals. Both sites provide publicly funded maternity care to over 3000 births per year and are located in areas with a diverse multicultural population. At both sites assessment and screening processes had been established for over five years and a co-ordinated response was in place for women identified with risk factors for poor mental health. The psychosocial assessment questions (see Table 1) are integrated in an administrative

database designed to record all data routinely collected from pregnant women in NSW, Australia. Midwives undertaking the booking visit use the questions on this administrative database to guide the assessment of women's physical, social and emotional health. The responses to the Edinburgh Depression Scale are also recorded on this database.

Recruitment

Midwives received information about the study through in-service sessions conducted by the researcher at each site, questions were answered and then interested midwives were asked to contact the researcher. The researcher then attended the antenatal clinic on days that the consenting midwives were working. Women were informed about the study via a letter of invitation included in the information package sent to women by the maternity unit prior to their booking visit. Women who were allocated to one of the participating midwives were then approached by a researcher when they arrived for their booking visit and asked if they had received the letter and if they were interested in participating in the study.

Study participants

Participants in the antenatal component of this study comprised 34 pregnant women (W) who were attending the antenatal clinic for their first appointment (the booking visit) and 16 midwives (M) and two student midwives (SM) who undertook psychosocial assessment and depression screening as part of their role in conducting the antenatal history and health assessment. Women were excluded from the study if they were under 18 years old or required an interpreter. This was necessary as the study focused on the interactions between professionals and women and this dynamic will be significantly altered if an interpreter is present.

Sixteen midwives and two student midwives participated in the antenatal observations. The average years of experience of the 16 midwives were five years and 12 of these midwives had worked an average of three years in the antenatal clinic (AC). Three of the participants were working in a midwifery group practice (MGP) (i.e. they worked in a continuity of care model where they see the same woman across pregnancy, birth and post partum).

Thirty four women participated in the antenatal component of this study. On average they were 30 years of age, almost one third (11 out of 34) spoke a language other than English and almost two thirds (20 out of 34) were born outside of Australia and 18 were having their first baby. The participants were well educated with 30 of the women having tertiary qualifications (see Table 2).

Table 2
Characteristic of women participants.

Women	N=34
Age	Average 30 years, range 21–41 years
Gestation at booking	Average 14 weeks, range 10–28 weeks
Born in Australia	14
Born in English speaking country other than Australia (Ireland, United States of America, United Kingdom)	5
Born in non-English speaking country	15
Spoke language other than English	11
Nulliparous	18 (of these 15 had had a previous pregnancy/s)
Married or living in defacto	34
Completed tertiary level education	30

Data collection

Data were collected via non-participant observation of the antenatal booking visit. The first author observed 34 booking visits. As a research team our preference was to observe each midwife on two occasions as this would assist us to identify patterns in the approaches to midwifery practice and would not place an undue burden on midwives working in the maternity unit. Nine of the 18 midwives or student midwives were observed on two occasions with different women. An observation tool (4D&4R) was developed for this study (XXX under review). The 4Ds (introDuce, Deliver, Deal and Debrief) were designed to record details about the overall approach taken by midwives to the psychosocial assessment and screening including how midwives introDuce the psychosocial questions and depression screening tool, how they Deliver the questions, Deal with positive responses from the woman to any of the questions and whether the midwife then DebrieFs the woman and offers her an opportunity to reflect on the impact of being asked the questions. Midwives were also observed for their communication style within the domains, such as their tone of voice, sitting position (e.g. facing the woman or the computer) and any shifts in the communication that may have been highlighted by facial expressions that indicated the midwife was surprised, concerned, empathic or agitated.

The observation tool was used in combination with detailed field notes to collect data related to the interactions of the participants during the assessment and screening process. Notations made within the field notes related to dynamics observed during the interaction between the midwife and the woman.

Brief interviews were conducted with the participating midwives directly following the observation. These lasted approximately five to ten minutes obtaining the midwives' impression of the assessment and if they experienced any challenges or alternatively, if they had felt particularly positive about the style they had used. These data were recorded in field notes and were not audio-recorded.

Data analysis

Content analysis was used to analyse the data recorded on the observation tool and the field notes (Krippendorff, 2004). The following questions were used to guide the analysis: how did the midwife greet the woman, how were the questions introduced, at what point in the consultation was the psychosocial assessment undertaken; on average how much time did the assessment take; how frequently were all psychosocial questions asked; how often were women invited to ask questions, what questions did they ask and how were they framed? Frequencies were used to analyse the data recorded on the structured observation tool and qualitative content analysis has been used to analyse the textual data from the field notes.

Findings

There were differences observed in the organisation of the antenatal booking visits at the two sites (see Table 3). The time allocated for bookings differed: at site A, one hour and at site B, one and a half hours was allocated, although the actual time taken for booking visits ranged from 20 minutes up to two and a half hours. Women had minimal wait times at the clinics, waiting eight minutes on average (site A) and 14 minutes (site B). When women did experience a long wait this usually related to the woman being confused about her appointment time.

Table 3
Organisational features/characteristics of antenatal booking visits.

Characteristics	Site A	Site B
Number of midwives assigned to histories	2–3 midwives per morning or afternoon clinic	2–3 midwives per morning or afternoon clinic
Average years of experience as midwife	2 years ($r=1-5$)	7 years ($r=3-10$)
Women booked for histories	6–8 women per morning or afternoon clinic	6–8 women per morning or afternoon clinic
Average wait times (minutes)	18 minutes ($r=0-120$)	11 minutes ($r=0-50$)
Allocated time for booking visit	1 hour	1.5 hours
Average duration of booking visit	43 minutes ($r=20-65$)	65 minutes ($r=25-120$)
Partner attendance	Excluded	Included partially, excluded from psychosocial assessment

Usually these women waited till their time came and were seen on that same day at the original booking time.

The greeting

Two main approaches to greeting the women were observed. In the first approach, 20 out of 34 midwives entered the waiting area, and called out the name of the woman to be interviewed. The expectation appeared to be that the woman would get up from her seat and follow the midwife. In the second approach, 14 out of 34 of the midwives approached the woman where she was sitting in the waiting room, introduce herself and briefly explained the process of the booking visit. Following this initial greeting most midwives at both sites then showed the woman to the bathroom to record her weight and demonstrated to the woman how to conduct a urinalysis herself before entering the clinic rooms.

Commencing the booking visit

In the initial stage of the booking visit, the midwives generally took one of two approaches: completing administrative tasks or spending time getting to know the woman in a conversational manner. In 21 out of 34 booking visits midwives were observed to commence the visit by completing administrative tasks such as the woman's own antenatal health record, entering details including the woman's address, results from blood tests, ultrasounds or other medical results. Statements such as, 'have you had any ultrasounds thus far in your pregnancy?' (M1) were common. At this point some midwives introduced the EDS for the woman to complete whilst the midwife continued filling out the forms. A smaller number of midwives (4/34) commenced the antenatal booking visit by simply asking 'What number baby is this? Or is this baby number 1?' (M12).

In the second approach midwives demonstrated a more conversational style. This was observed in 13 out of 34 bookings. Here midwives appeared to take time to interact with the woman and her partner (if present) in an engaging way. Seating to face the woman (and her partner) rather than the computer, these midwives started with general questions such as; how have things been going? And how are you feeling about being pregnant. This style of interaction prior to the information gathering phase appeared to open up opportunities for the woman and their partners (P) to share their experience of adjusting to being pregnant and what this may have brought up for them in their relationship.

M8—Is this your first pregnancy?

W20—Yep

M8—how you feeling about that?

P20—A little bit worried

M8—in what way?

P20—Bringing a life into this world, into society makes me a bit nervous.

Table 4
Midwives approach to introducing, explaining and to psychosocial assessment.

Midwives action or response related to psychosocial assessment	Number of occasions (observations $n=34$)
Provided an introduction to the overall visit	22
Introduced the questions at least once during the interview	29
Introduced the psychosocial questions at the beginning of the assessment	13
Introduced prior to asking	16
Introduced both at the beginning and prior to asking	9
Provided a rationale for asking the questions	21
Described the privacy act before asking DV questions	20
Responded to questions asked by the woman	27
Debriefed the woman following sensitive questions	4

Introducing the overall visit and psychosocial assessment questions

Table 4 provides an overview of data recorded on the observation tool describing whether midwives introduced the questions, provided a rationale and/or explained the privacy act to the woman. Observations also included if the woman asked questions about the process and whether the midwife responded. The administrative database also prompts the midwife to read the privacy act to the woman prior to asking the domestic violence screening questions. In 20 of the 34 observations the midwife read the privacy act off the computer screen word for word. In the remaining assessments, the midwife did not read the privacy act at this point nor refer to it at any other stage in the booking visit.

The participating midwives then introduced the content of the booking visit. In more than half of the observations (22/34) the midwife explained to the woman what to expect in the interview. In doing this some midwives (9/34) appeared slightly awkward or uncomfortable informing the woman about the amount of questions included in the overall visit and indicated to the woman that there would be a number of questions about her medical, psychosocial and obstetric history, for example, one midwife stated '...a whole heap of questions' (M5). Some midwives appeared more comfortable (13/34) to specifically mention the psychosocial questions in the initial introduction, for example 'There's a whole load of questions, about your physical health and there's a section on your emotions and social supports...' (M8).

If the midwife did not introduce the psychosocial assessment at this point then this would occur just prior to the questions being asked (16/34). Nine midwives introduced the psychosocial assessment questions at both points in time. A common lead into the psychosocial questions was:

M9—People come from all walks of life so we have to ask a list of personal questions to try to identify women who may be at

high risk of postnatal depression, to help prepare you for mothering and see if you need any extra support.

These introductions appear to be efforts to place women at ease regarding the questions and to normalise the process of assessment –‘we get everyone to answer some questions’ (M22). Midwives also offered the woman an opportunity to decline ‘they are a bit sensitive so if you don’t want to tell me you don’t have to, it’s just so we can identify women who might be at risk later in pregnancy’ (M20).

Midwives also tried to ascertain the level of preparation women had for psychosocial assessment. For example, a midwife asked ‘When you received information from the hospital...did that explain what would happen today?’ (M10). Other midwives sought to prepare the woman themselves as illustrated here ‘there’s also some questions about how you were treated when you were a child’ (M12). On one occasion, a woman pre-empted what was to be asked and interrupted the midwife introducing the questions saying ‘I’ll tell you one thing, he was a bit of a pot smoker’ (W34).

Delivery of the psychosocial questions

Timing

The administrative database provided a structure for the midwives to follow locating the psychosocial assessment questions approximately midway in the booking visit. However, in the observed interactions, the psychosocial assessment, depression screening and domestic violence questions were almost always (32/34) undertaken by the midwives at the end of the booking visit and prior to undertaking a physical assessment of the woman including fetal heart monitoring. During interviews with midwives, some explained they positioned these questions towards the end so that they could take time to explore any risk factors that may be identified once the other history taking was complete (FN M10).

Approach and style

Two approaches to the delivery of the psychosocial questions were observed: a structured approach (13/34) and a flexible approach (21/34). When the midwives used a structured approach they were more directive for example, the questions were read directly from the computer and the woman was instructed to complete tasks as illustrated in the following examples.

M2—(hands the woman the EDS) *I want you to do this*

W8—do you want me to tick?

M2—(explains hastily) *underline, underline*

Or in this example:

SM1—No anxiety or depression?

W4—No. Is that from me or my family?

SM1—*Just you, I’ll tell you when we get to your family?*

(This family history of mental health issue was not revisited by the midwife)

When midwives used a flexible approach they varied the wording or the order of the timing of the questions. This appeared to assist the woman in understanding the questions and often these midwives provided a rationale for what was being asked. A more flexible style of communicating appeared to result in a reciprocal exchange between the woman and the midwife. In field notes it was noted that ‘the midwife took time to respond to the woman’s answers and explore her concerns, and this appeared to facilitate a more collaborative approach to decision making and problem solving’ (FN9). A sense of friendliness and warmth appeared from the midwife and was evidenced by soft facial

gestures, soft or neutral tone of voice, smiling and a balance of eye contact between the computer and woman (FN9).

Midwives attempted to minimise the impact on the women, to ‘soften’ the sensitive psychosocial questions or to prepare the woman for the coming questions.

SM1: we just ask some questions about your childhood, just because sometimes it can bring back memories, or

M5: the next question relates to your childhood and any abuse that may have occurred. The reason why this is important is it may be an issue for you or for women during birth.

A number of midwives were observed to modify the questions. In interview with the midwives, some reported that this was often done in order to assist the woman in understanding the questions’ (FN17 interview with SM1) and was especially evident when the midwife was interacting with a woman from a non-English speaking background (FN17). Midwives often reframed the question they had just asked. They first read the question from the computer screen as illustrated here ‘Are you a confident person’ (M2) then reframed the question asking ‘are you a strong person?’ (M2). Likewise, the computer-based question ‘As a child were you hit or abused, any way physical, emotional or sexual?’ was reframed by the midwife asking ‘when you were a little child did your parents or any of your family members hit you or rape you or anything like that’ (M2). Midwives commonly used terminology that represented their own understanding of what the question meant such as ‘are you a neat freak?’(M8).

Midwives’ response to positive answers

In 26 out of 34 of the interactions observed, women talked about or disclosed at least one issue that was a risk factor, including previous history of child sexual assault or recent stressor related to loss of income or moving house (NSW Department of Families). In only four of these 26 interactions these issues were not explored further. In the remaining 21 instances the midwives followed up with further clarification questions such as ‘have you ever been diagnosed?’ when referring to a past mental health history or ‘did you want to tell me about it?’ (M12 following a woman’s disclosure of history of trauma).

In general midwives were observed to explore risk factors with women in an empathetic manner, softening their voice, maintaining eye contact and gently enquiring about the issue identified (FN29). While exploring the issues the midwife sought to know if the woman identified the risk as a problem and whether she required support. This is demonstrated when W28 discloses a previous history of anxiety and M16 responded with ‘how long did this last for and did you receive any treatment...and how do you feel now?’ During this disclosure of personal stories to midwives, four midwives were observed to reflect on their own personal experience and share this with the women ‘I know when that happened to me I was like totally not expecting it’ (M9). This may be considered at the time unnecessary or moving outside professional boundaries, however, when the woman had responded positively to psychosocial risk questions the midwife took time to explore her concerns (FN20). The midwife was observed pacing the psychosocial assessment questions to enable the woman to open up and to then explore issues.

A common response from some midwives to a woman who did disclose a concern or issue was ‘that’s fine, that’s okay’. For example during the domestic violence screening when women are asked if they are frightened of their partners six women replied ‘No, I think he’s frightened of me’ (W15). Midwives did not appear to identify this as an area for further exploration but replied with ‘that’s fine, that’s okay’ (M3). Another example of the use of this response occurred when one woman disclosed that she had drunk alcohol in pregnancy stating ‘I drink a bit of alcohol’ (W2) and the midwife responded with ‘that’s fine, that’s okay’

(M2). In these scenarios the woman may have indicated to the midwife in other ways such as their body language, etc. that there were no further issues that needed to be explored.

Debriefing

Due to the sensitive nature of the questions, 'debriefing' was included as a criterion used by the researchers to observe if the midwife offered a woman support or invited her to talk further or reflect on any issues or concerns raised during the interview. For example, if a woman was asked to recall trauma that may still be affecting her emotional and psychological well-being, the midwife has a duty of care to ensure the woman leaves the encounter feeling that she has received appropriate support. Of the 34 midwife–woman interactions observed, debriefing following the sensitive questioning only occurred in four interactions. In these four exemplars midwives generally used the phrase 'You okay?' (M15) or 'Are you okay to move on?' (SM2). These statements were used following the screening for domestic violence and questions about previous pregnancies, where women are encouraged to talk about previous miscarriage, termination of pregnancy or stillbirth.

Discussion

There are increasing moves internationally to standardise and make routine the psychosocial assessment and depression screening of all pregnant women. This study is one of the first Australian, and as far as we are aware, international studies to observe and report on the process of psychosocial assessment of pregnant women undertaken by midwives. The study has found that while many of the participating midwives demonstrated skills in undertaking psychosocial assessment responding appropriately to disclosure of sensitive issues, there were many instances where practice could be improved. In the main, midwives introduced themselves and provided information about what to expect during the assessment period. Around 40% of midwives followed a structured process using the computer database, reading the psychosocial questions directly from the screen and positioning the questions toward the end of the booking visit. Other midwives adapted their approach asking specific questions when they perceived it to be appropriate. Often midwives modified the questions, using different words or phrases when asking or repeating the question.

The style or approach a midwife takes to psychosocial assessment is important as this may impact on women's comfort in disclosing their concerns and on her relationship with midwives and the maternity service. Factors that may influence the approach that a midwife takes include experience of the midwife (Ramsay et al., 2002), organisational support for education, training and exposure to the practice of others (Marron and Maginis, 2009), the opportunity for clinical supervision (Chew-Graham et al., 2009), their own personal life experiences (Mollart et al., 2009) and the model of midwifery care the midwife is working in. Only three midwives observed in this study were providing continuity of care through a case load model. While these three midwives took the more conversational or relational approach to the assessment, overall their approach did not differ from the other 15 midwives who were not working in a case load model of care.

Midwives who took a structured, more directive approach appeared to be focused on 'getting the job done'. It can be argued that this approach demonstrated midwives' priority to comply with institutional protocols related to risk management of mental health issues. Midwives allegiance to the protocol and the institution, rather than to the woman, has been reported by

others examining differences between midwives who work in fragmented hospital-based maternity care versus those in continuity models or in the community (Hunter, 2004). In other ethnographic research, midwives have been observed to communicate that their priority is getting through the days' work (Hunt and Symonds, 1995) or as Dykes (2006) describes, managing the production line. Furthermore, the increasing technological focus in midwifery care has reinforced the position of the midwife as a technological expert. For example Burns et al. (in press) noted when observing midwives providing breastfeeding support, the majority approached breastfeeding as if it were a complicated, mechanical process using their technical knowledge and expertise to direct and instruct women about how to breastfeed and only a few were observed to interact in a relational way with women attempting to ascertain the type of breastfeeding support and information she required.

Research (Schmied et al., 2011; Buist et al., 2007) indicates that women value and benefit from care that reflects a more egalitarian or partnership approach. In a qualitative study examining women's experiences of communication in antenatal care, Raine et al. (2010) reported that women valued empathy and compassion, with a willingness to engage in dialogue, and to genuinely attend to the circumstances and needs of individual women. Schmied et al. also report that women, in relation to breastfeeding support, preferred when midwives established an 'authentic presence' with them, including taking time to listen to their needs and concerns. This approach or style was demonstrated by two thirds of the participants in this study who used a more informal and conversational style. This approach has been commonly observed in models of continuity of midwifery care where the midwife–woman relationship, characterised by trust and reciprocity, is prioritised (Hunter, 2006; Hunter et al., 2008). Here the midwife works towards gaining a shared understanding (Davis and Day, 2010) between themselves and the woman and may lead to a greater likelihood that sensitive issues will be disclosed.

It is important to consider how well trained and supported midwives are to undertake psychosocial assessment, particularly in the context of a fragmented and busy maternity care system where the midwife, having obtained sensitive information from a woman, is unlikely to see that woman again. Authors in the United Kingdom and in Australia indicate that while midwives have good knowledge of mental health concerns such as antenatal depression, they are not adequately trained and, therefore, lack confidence in undertaking assessment and screening for antenatal depression (Stewart and Henshaw, 2002; Ross-Davie et al., 2006; Jomeen et al., 2009; Jones et al., 2012). Jones et al. (2012) note that midwives' perceived inability to offer care and support may have an adverse influence on their motivation, and likelihood of engaging in emotional care in practice. Furthermore, Jones et al. (2011) report systemic issues such as time constraints encountered by midwives need to be addressed to support the delivery of effective emotional care to childbearing women. In related work, Cowley and Houston (2003) examined the role of the health visitor in undertaking psychosocial assessment and reject a structured format that does not allow for the flexibility required to elicit sensitive information. They, further, suggest that sensitive information should be uncovered by the health professional during their ongoing contact with a woman, rather than through a specific assessment process.

The concern about the need for training and support for midwives and other health professionals undertaking psychosocial assessment has led to the development and testing of a training programme (ANEW) focused on building the capacity of midwives and other professionals (general practitioners) to create a therapeutic environment more conducive to disclosure of

sensitive information (Hegarty et al., 2007). The ANEW programme involved training in asking key questions in a sensitive way to explore risks or concerns clinicians may have for a woman rather than relying on a structured tool to provide these prompts. With enhanced listening skills, Hegarty et al. (2007) argue that clinicians can detect important cues during conversation and provide psychosocial support to those women in need. In the study reported in this paper, the majority of midwives were observed to deliver most of the questions in a sensitive manner, often turning away from the computer to face the woman directly and lowering their tone of voice. Further, the work of Davis and Day (2010) on the family partnership model has been used in some Australia jurisdictions for CFHN (Kemp et al., 2011) and in the UK (Kirkpatrick et al., 2007) as the basis of professional training. This training is also being offered to midwives in some locations in Australia.

The modification of questions observed in this study may relate to midwives discomfort about asking questions that may be perceived as intrusive or too direct (Cowley and Houston, 2003). This modification process may be adopted by midwives to minimise the impact of the questions on themselves and on the women they are asking. However, modifications such as the reframing of questions, as seen in this study, may alter the meaning of the question, leaving room for misinterpretation by the woman and/or the midwife.

This study has highlighted the ongoing need for support for midwives and opportunities to discuss their own experiences of listening and responding to women's trauma experiences. Mollart et al. (2009) report that midwives require access to structured support programs that include ongoing training, education and supervision to minimise the negative impact experienced in uncovering stories of women's trauma. To help facilitate the psychosocial assessment and depression screening process, interventions may be provided such as clinical supervision and support, but this is only one part of what is required to enhance the experience of staff (Chew-Graham et al., 2009). Chew-Graham emphasise the need for organisations to take responsibility to design and encourage environments that are conducive to the exploration of sensitive issues.

Study limitations

This is a small study where the practice of midwives was observed in two units, both of which have been involved in the process of psychosocial assessment for some time. Only 18 midwives were observed in interaction with 34 women. Not all midwives agreed to participate and it may be that those who did not agree have different approaches to this assessment or feel more or less confident in the process. Most of the women who agreed to participate have also come from a higher level of educational qualifications.

Conclusion

The approach a midwife takes to routine psychosocial assessment and depression screening may have a significant impact on a woman. This study sought to observe and describe the process of psychosocial assessment undertaken by midwives in two sites in NSW. Overall, the participating midwives appeared to approach this process positively and adapted their practice through the blending and varying of the structure or positioning of the questions in the interaction. Although the allocated time to assessments varied across the two sites, in all instances observed in this study, midwives appeared to have adequate time to conduct the assessment. Some modified the questions to facilitate

comprehension of the questions or minimise the discomfort to them and/or women. Those modifications may, however, alter their meaning and impacting on the assessment outcomes. To maintain the assessment uniformity and conduct it in ways that support women, midwives require organisational support in ongoing training, education and clinical supervision.

This process of psychosocial assessment in pregnancy and following birth is now mandated in NSW, Australia. It is yet to be determined if that is the most appropriate approach to identify needs and concerns of women and their families. To date, there is limited evidence that the early identification of psychosocial risk leads to improved outcomes through access and uptake of interventions (Yelland et al., 2009) and the impact of such assessments on the development of the midwife–woman relationship are unknown. Further research in this area is required.

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Reference

- Austin, M.-P., Colton, J., Priest, S., Reilly, N., Hadzi-Pavlovic, D., 2011. The Antenatal Risk Questionnaire (ANRQ): acceptability and use for psychosocial risk assessment in the maternity setting. *Women and Birth* [Epub ahead of print – 2011 Jul 16].
- Beyondblue, 2011. Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. A guideline for primary care health professionals. Melbourne: Beyondblue: The National Depression Initiative.
- Briggs, C., 2006. Nursing practice in community child health: developing the nurse–client relationship. *Contemporary Nurse* 23, 303–311.
- Buist, A., Ellwood, D., Brooks, J., Milgrom, J., Hayes, B.A., Sved-Williams, A., 2007. National program for depression associated with childbirth: the Australian experience. *Best Practice & Research Clinical Obstetrics & Gynaecology* 21, 193–206.
- Burns, E., Fenwick, J., Sheehan, A., Schmied, V., 2013. Mining for liquid gold: midwifery language and practices associated with early breastfeeding support. *Maternal and Child Nutrition* 9 (1), 57–73. [10.1111/j.1740-8709.2011.00397](https://doi.org/10.1111/j.1740-8709.2011.00397).
- Chew-Graham, C.A., Sharp, D., Chamberlain, E., Folkes, L., Turner, K.M., 2009. Disclosure of symptoms of postnatal depression, the perspectives of health professionals and women: a qualitative study. *BMC Family Practice* 10 (7), [10.1186/1471-2296-10-7](https://doi.org/10.1186/1471-2296-10-7).
- Cowley, S., Houston, A.M., 2003. A structured health needs assessment tool: acceptability and effectiveness for health visiting. *Journal of Advanced Nursing* 43, 82–92.
- Davis, H., Day, C. (Eds.), 2010. *Working in Partnership with Parents*, 2nd edn. Pearson, London.
- Dykes, F., 2006. The education of health practitioners supporting breastfeeding women: a time for critical reflection. *Maternal and Child Nutrition* 2, 204–216.
- Hegarty, K., Brown, S., Gunn, J., Forster, D., Nagle, C., Grant, B., 2007. Women's views and outcomes of an educational intervention designed to enhance psychosocial support for women during pregnancy. *Birth* 34, 155–163.
- Hunt, S., Symonds, A., 1995. *The Social Meaning of Midwifery*. MacMillan Palgrave, London.
- Hunter, B., 2004. Emotion work and boundary maintenance in hospital based midwifery. *Midwifery* 21, 253–266.
- Hunter, B., 2006. The importance of reciprocity in relationships between community-based midwives and mothers. *Midwifery* 22, 308–322.
- Hunter, B., Berg, M., Ingela, L., Olafsdottir, O.A., Kirkham, M., 2008. Relationships: the hidden threads in the tapestry of maternity care. *Midwifery* 24, 132–137.
- Johnson, M., Schmied, V., Lupton, S.J., Austin, M.P., Matthey, S.M., Kemp, L., Mills, A., Meade, T., Yeo, T., 2012. Measuring perinatal mental health risk. *Archives of Women's Mental Health* 15 (5), 375–386. <http://dx.doi.org/10.1007/s00737-012-0297-8>.
- Jomeen, J., Glover, L.F., Davies, S.-A., 2009. Midwives' illness perceptions of antenatal depression. *British Journal of Midwifery* 17, 296–303.
- Jones, C.J., Creedy, D.K., Gamble, J.A., 2011. Australian midwives' awareness and management of antenatal and postpartum depression. *Women and Birth* 25, 23–28.
- Jones, C.J., Creedy, D.K., Gamble, J.A., 2012. Australian midwives' attitudes towards care for women with emotional distress. *Midwifery* 28, 216–221.

- Karatas, J.C., Matthey, S., Barnett, B., 2009. Antenatal psychosocial assessment: how accurate are we in determining 'low-risk' status? A pilot study. *Archives of Women's Mental Health* 12, 97–103.
- Kemp, L., Harris, E., McMahon, C., et al., 2011. Child and family outcomes of a long-term nurse home visitation programme: a randomised controlled trial. *Archives of Disease in Childhood* 96, 533–540.
- Kirkpatrick, S., Barlow, J., Stewart-Brown, S., et al., 2007. Working in partnership: user perceptions of intensive home visiting. *Child Abuse Review* 16, 32–46.
- Krippendorff, K., 2004. *Content Analysis: An Introduction to its Methodology*. Sage Publications, California.
- Marron, C.A., Maginis, C., 2009. Implementing family health assessment: experiences of child health CFHN. *National, Paediatric and Child Health Nursing* 12, 3–8.
- Matthey, S., Phillips, J., White, T., et al., 2004. Routine psychosocial assessment of women in the antenatal period: frequency of risk factors and implications for clinical services. *Archives of Women's Mental Health* 7, 223–229.
- Matthey, S., White, T., Phillips, J., Taouk, R., Chee, T., Barnett, B., 2005. Acceptability of routine antenatal psychosocial assessments to women from English and non-English speaking backgrounds. *Archives of Women's Mental Health* 8, 171–180.
- McCourt, C., 2006. Supporting choice and control? Communication and interaction between midwives and women at the antenatal booking visit. *Social Science and Medicine* 62, 1307–1318.
- Mollart, L., Newing, C., Foureur, M., 2009. Midwives' emotional wellbeing: Impact of conducting a Structured Antenatal Psychosocial Assessment (SAPSA). *Women and Birth* 22, 82–88.
- Murray, L., Cooper, P., Hipwell, A., 2003. Mental health of parents caring for infants. *Archives of Women's Mental Health* 6, 71–77.
- Najman, J.M., Hallam, D., Bor, W., et al., 2005. Predictors of depression in very young children. A prospective study. *Social Psychiatry and Psychiatric Epidemiology* 40, 367–374.
- NSW Department of Health, 2009. *NSW Health/Families NSW Supporting Families Early Package—SAFE START Strategic Policy*. NSW Department of Health, North Sydney.
- Priest, S.R., Austin, M.P., Sullivan, E., 2005. Antenatal psychosocial screening for prevention of antenatal and postnatal anxiety and depression (protocol). *Cochrane Database of Systematic Reviews* (1).
- Raine, R., Cartwright, M., Richens, Y., Mahamed, Z., Smith, D., 2010. A qualitative study of women's experiences of communication in antenatal care: identifying areas for action. *Maternal Child Health* 14, 590–599.
- Ramsay, J., Richardson, J., Carter, Y.H., Davidson, L.L., Feder, G., 2002. Should health professionals screen women for domestic violence? Systematic review. *British Medical Journal* 325, 314, <http://dx.doi.org/10.1136/bmj.325.7359.314>.
- Robinson, M., Mattes, E., Oddy, W.H., et al., 2011. Prenatal stress and risk of behavioral morbidity from age 2 to 14 years: the influence of the number, type, and timing of stressful life events. *Development and Psychopathology* 23, 507–520.
- Ross-Davie, M., Elliott, S., Sarkar, A., Green, L., 2006. A public health role in perinatal mental health: are midwives ready? *British Journal of Midwifery* 14, 330–334.
- Schmied, V., Beake, S., Sheehan, A., McCourt, C., Dykes, F., 2011. Women's perceptions and experiences of breastfeeding support: a metasynthesis. *Birth* 38, 49–60.
- Stewart, C., Henshaw, C., 2002. Midwives and perinatal mental health. *British Journal of Midwifery* 10, 117–121.
- Yelland, J.S., Sutherland, G.A., Wiebe, J.L., Brown, S.J., 2009. A national approach to perinatal mental health in Australia: exercising caution in the roll-out of a public health initiative. *Medical Journal of Australia* 191, 276–279.