Assessing mental health during pregnancy: an exploratory qualitative study of midwives' perceptions

Abstract

Background: Mental health disorders are estimated to affect between 10% and 20% of women who access maternity services and can be defined as a public health issue due to the potential consequences for women, children and families. Detecting problems early in pregnancy can significantly improve outcomes for women and their families. However, mental health problems are not being consistently identified in routine midwifery practice and little is known from current literature about midwives' practice in relation to current national guidelines or the impact models of care have on assessing maternal mental health.

Objective: To identify midwives' views about barriers and facilitators to screening for mental health in pregnancy using current UK guidelines.

Design: Nine community midwives from a single district general hospital in the south of England were recruited to take part in focus groups. Thematic analysis was used to extract key themes from the data.

Findings: Three key themes were identified from the focus groups and included *system factors, social factors and trust.* Barriers and facilitators to screening maternal mental health were associated with the initial 'booking' appointment' and differences in models of care. Barriers to screening were defined as high workload, poor continuity, and a lack of trust between women and midwives.

Conclusions: This study highlights key barriers and facilitators associated with mental health screening during pregnancy, including issues of trust and uncertainty about women's willingness to disclose mental health conditions. Further research is required to evaluate the relationship between women and midwives in contemporary practice and the influence this may have on maternal mental health.

Key Words

Qualitative; maternal mental health; screening; midwives' perceptions; continuity; trust.

Introduction

Mental health (MH) problems are among the most commonly reported complication of childbearing, affecting up to 20% of women during and after pregnancy (National Institute for Health and Care excellence (NICE), 2014; World Health Organisation (WHO), 2019). In the United Kingdom (UK), psychiatric problems are the leading cause of maternal death up to the first year postpartum and maternal mental health (MMH) has become increasingly recognised as an area of considerable importance. Despite this, figures remain unchanged in the most recent triennial report (2014-2016) and in over half of the cases reviewed, it was found that improvements to care could have made a difference to the outcome (Knight et al, 2018).

Although early recognition can improve adverse outcomes, adequate assessment of MH is an area requiring improvement (Williams et al, 2016). The UK Royal College of Obstetricians and Gynaecologists (RCOG) recently carried out a cross-sectional survey of postnatal women living in Britain and a significant proportion (69%) reported low mood following childbirth. Despite this, more than a quarter of the sample reported never being asked about their MH during pregnancy and several participants felt their antenatal MH assessment did not encourage disclosure (RCOG, 2017).

There are several reasons why identifying MH conditions during pregnancy can be challenging. Transient symptoms of pregnancy such as sickness and fatigue can make it difficult for women to recognise their own changing emotions, and stigma associated with MH continues to be a significant barrier to disclosure (Kingston et al, 2015). In a qualitative study exploring midwives' and women's views of MMH screening, midwives felt that early pregnancy is not a suitable time to screen for MH due to symptoms associated with this time and some reported occasionally avoiding the assessment as it felt intrusive (Williams et al. 2016). Midwives interviewed as part of another study also described the MMH assessment as intrusive, this was compounded by lack of MH expertise and time restraints during appointments (McGlone et al, 2016). Continuity of carer has also rarely been established in early pregnancy, which may be significant as women with existing mental illness have reported that knowing and trusting their midwife was key to disclosure (Phillips and Thomas, 2015).

Assessing Mental Health in Pregnancy:

In the UK, midwives are usually a woman's primary health care professional throughout pregnancy and up to the 14th postnatal day, when most women are discharged to their GP and health visitor (NICE, 2015). The current UK guidelines for managing antenatal and postnatal mental health recommend midwives first assess women's emotional wellbeing

using the two '*Whooley questions'* (Figure 1.) at the initial booking appointment (NICE, 2014), which is often the first contact with a midwife, ideally occurring before 12 weeks gestation.

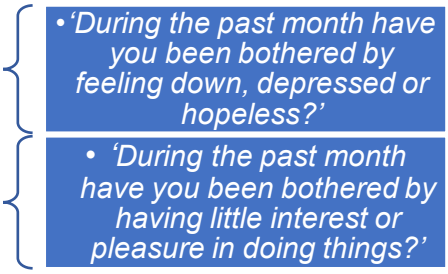


Figure 1. The Whooley Questions.

These questions were developed by Whooley et al. (1997) to screen for depression in the general public and were validated on a sample of mostly middle-aged men (97%). More recently, Mann et al. (2015) validated the 'Whooley questions' against the diagnostic standard DSM-IV and although 100% sensitivity was demonstrated (CI 77% - 100%), women in the study answered the 'Whooley questions' in a research setting during the second trimester of pregnancy, which is not comparable to asking women at their initial antenatal booking appointment. Howard et al. (2018) examined the diagnostic accuracy of the 'Whooley questions' compared to the Edinburgh Postnatal Depression Scale (EPDS) and the Structured Clinical Interview DSM-IV-TR (SCID) and found the 'Whooley questions' were less sensitive than previously documented when asked during the antenatal booking appointment (41%). Despite this, specificity was high (95%) and they concluded that the 'Whooley questions' are a useful tool for use in early pregnancy.

Little is currently known about midwives' practice in the context of MMH screening. International studies have investigated midwives' knowledge and confidence of MMH (McCauley et al. 2011) but the 'Whooley questions' are not the recommended perinatal screening tool in a number of international guidelines and the EPDS is more commonly favoured (Centre of Perinatal Excellence, 2017). Both William's (2016) study and McGlone's (2016) study were conducted with UK midwives and demonstrated some of the limitations associated with asking the Whooley questions. However, both studies focused specifically on the Whooley questions and did not explore any variations in midwives' practice, the context of care, or views of current NICE guidelines (2014) which include the use of other MH assessment tools.

There are significant disparities surrounding screening practices for MMH both in the literature and across international guidelines and midwives' practice in relation to this

remains unclear. This article explores the findings from a qualitative study, examining midwives' experiences of screening MMH and their practice in relation to UK national guidelines. Building on previous research, this study aims to establish if variations in midwifery practice and models of care make a difference to how the mental health assessment is perceived and explores some of the barriers and facilitators experienced by midwives in contemporary practice.

Aims:

Our study addressed the following research aims:

- To identify barriers and facilitators to screening mental health during pregnancy through midwives' experiences.
- To gather evidence about variations in midwives' practice during mental health screening.
- To examine midwives' views of current guidelines for antenatal screening for mental health.
- To explore how current models of care impact upon the maternal mental health assessment.

Methods

A qualitative study was conducted with community midwives from a single district general hospital in the South West of England. At the time this study took place, the service provided care for approximately 6,000 women per annum and employed 150 whole time equivalent midwives, 43 of whom, worked in the community. Community midwifery refers to care delivered in an outpatient setting, either in women's homes or in local clinics. The midwives who participated in the study worked in teams divided by geographical area, covering approximately a 60-mile radius. One team cared exclusively for women with complex social and mental health needs across the district. Typically, the women cared for by this team have more appointments, are seen at home and have increased continuity. For the purposes of this study, the team is referred to as the *vulnerable women's team* (VWT), whilst other teams are referred to as *generic teams*.

Ethical approval:

Ethical approval was obtained from the faculty research ethics committee and the Trust's Research and Development department (SGREC 17.0010 FREC 2017-03-008). Written information was provided to all community midwives at the Trust and written consent was received from those taking part.

Sampling strategy:

Convenience sampling was initially used to inform the entire community team about the study by email (n=43) but the response to this approach was limited, largely due to the remote nature of community midwifery making access to email challenging. Therefore, purposive sampling was subsequently used to invite 27 community midwives with differing levels of experience, had experience of the initial antenatal booking appointments and therefore screened for MH in pregnancy and were available to attend the scheduled focus groups. There were no specific exclusion criteria.

Patient and Public Involvement:

A meeting with the Trust's senior midwifery team and five patient and public representatives was carried out during the study design stage to discuss the rationale for the project and the intended study design. The patient representatives had all previously birthed with the service and were involved in regular meetings about service improvement. Those attending described their own experiences and the barriers surrounding MH screening during pregnancy. This helped to inform the research question and the context of the focus groups whilst also confirming relevance of the study to current practice and public opinion.

Data Collection Method:

Focus groups are a recognised method for investigating the experiences of service providers and whilst individual interviews were considered, focus groups were chosen to explore a range of views and assess consensus through variations of opinion (Barbour, 2007). Focus groups were carried out throughout May 2017 and groups were separated by seniority, meaning junior midwives were in one group together and more senior midwives were in another. This was to minimise the potential for midwives giving socially desirable answers in front of more senior colleagues and vice-versa.

The focus groups were conducted by the researcher and a senior member of the midwifery team with prior experience of qualitative interviewing, neither had a direct working relationship with those participating. The topic guide (Table. 1) was semi-structured and designed to encourage discussion around the key objectives of the study. For example, MH screening tools were included to promote discussion around variations in practice. The topic guide was developed only for this study and piloted on two senior community midwives who were not involved in the main study. It was suggested from the pilot that each focus group include at least one midwife from the VWT to encourage discussion on differences in models of care. Focus groups lasted 40-60 minutes, were audio recorded and field notes documented, the recordings were later transcribed verbatim by one of the researchers. To

protect anonymity, all participants were described by individual study numbers throughout transcriptions.

Table 1: Topic guide for focus groups

1. *Ground rules for focus group and consent.*
2. *Set the scene: Discussion around current practice for screening MH in pregnancy.*
3. *Discuss the 'Whooley questions'; advantages and disadvantages.*
4. *Discuss opinions on the safety and effectiveness of current methods of screening.*
5. *Discuss other tools for assessing MH during pregnancy e.g. EPDS*
6. *Final comments and close.*

Data Analysis:

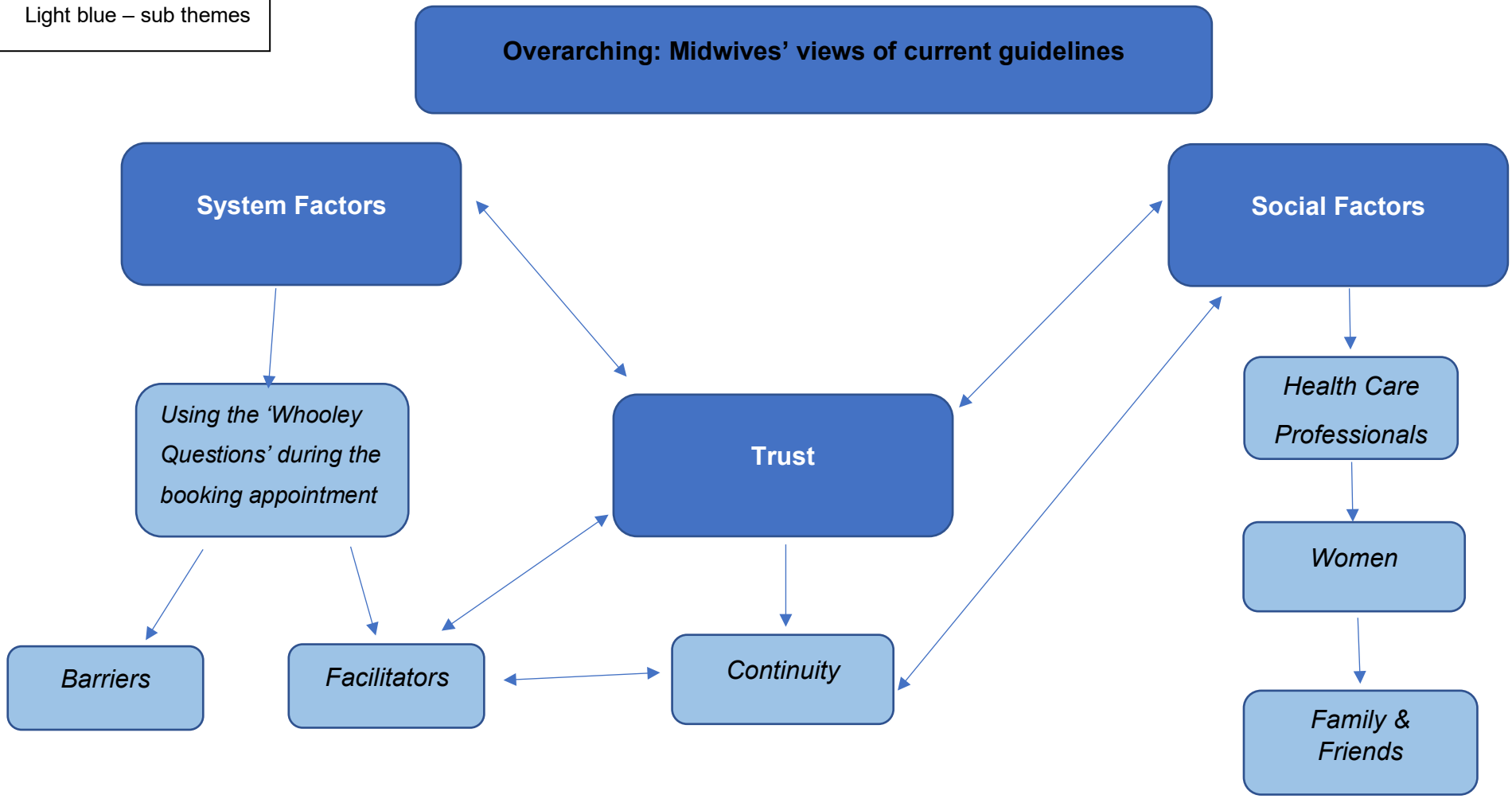
As this is a relatively under researched area of the literature and because our topic guide was only semi-structured, data was analysed using the six stages of Braun and Clarke's (2006) thematic analysis and within this, an inductive approach was chosen. This means themes were developed from the data themselves, rather than from our prior analytical perspectives. Focus groups were transcribed manually, manuscripts were then reviewed and codes assigned. Codes were condensed into categories and theme maps were used to help form overarching themes and sub-themes (Figure 2. Detailed examples in supplementary data). The final stage involved each researcher individually reviewing the dataset to explore how themes interacted with the initial research question.

Although analysis was carried out primarily by *X*, to improve the rigour or 'trustworthiness' of the data, the process was overseen by *Y* who checked for inconsistencies between the findings and the raw data. By utilising analyst triangulation, we examined individual themes in comparison to the initial discussions, whether the research process was replicable and checked for additional data missed during coding.

Key:

- Dark blue – overarching themes
- Light blue – sub themes

Figure 2: Theme Map



Findings

The constraints of the eligibility criteria and the needs of the service meant that whilst we were able to hold four focus groups, the numbers participating in each group were smaller than planned (2-3). A total of nine community midwives were recruited, of whom, three worked in the VWT. Midwives ranged from newly qualified to managerial level and the length of time in practice ranged from eight months to 11 years (Table 3). All those recruited were degree educated and none had completed formal perinatal mental health (PMH) training.

Length of time since qualifying	**Number of midwives *(n= 9)***	**Description of midwife grades**
≤ 1 year	2	**Junior:** Midwives in their 1st preceptor year after qualifying, still working towards signing off their competency skills such as cannulation, suturing and ward management.
2 – 4 years	3	**Mid-grade:** Completed preceptor year but do not yet manage other staff members and have under 5 years of experience.
5 + years	4	**Senior:** Over 5 years of experience as a midwife and have some line management responsibilities.

Table. 3. Sample Characteristics

Themes:

Three key themes emerged from the data; *system factors, social factors, trust* and the overarching theme, *midwives' views of current guidelines for assessing MH* answered the primary objective. The themes describe the challenges faced in contemporary midwifery practice and reflect how current models of care impact MMH screening. Findings are discussed under the three key themes, with extracts from the transcripts used to illustrate these themes.

System Factors:

The theme *system factors* is presented first as it sets the scene, describing the influence of workflow and models of care on MMH screening.

Using the 'Whooley Questions' during the booking appointment:

All of the participants discussed their views and experiences of using the 'Whooley questions'. Whilst some felt that the questions provide consistency, demonstrating to women that midwives are there to discuss their emotional concerns, the majority felt the questions lacked the appropriate depth to explore MH problems sufficiently.

> *'I think they are two very short and very brief questions to identify what could be a plethora of illness'' (Junior Midwife.009. VWT)*

> *'I think they're very prescriptive and a little bit restrictive' (Mid-grade Midwife. 007. VWT)*

Some of the midwives however felt these difficulties were more reflective of contextual challenges associated with assessing MMH during the booking appointment. Midwives described this appointment as an inappropriate time to explore MMH due to the confounding symptoms of early pregnancy, such as nausea and tiredness and limited time to adequately explore MH or form a rapport with women.

> *'A lot of the time they go yeah I have felt rubbish but I've been vomiting, I'm knackered, you know. Therefore, I've not been able to leave the house. So yeah actually I haven't had very much interest in doing things' (Senior Midwife. 004. Generic team)*

> *'One of my issues with it is you're asking all these really invasive questions twenty minutes after you're meeting this lady for the first time and if it's not in their nature to disclose, they're not going to be disclosing at that booking appointment.' (Mid-Grade Midwife.006. Generic team)*

Whilst some of the more senior midwives reported using more conversational methods to assess MH, none of the midwives reported using any other screening tools and few could name other tools. This is despite the inclusion of the Generalised Anxiety Disorder 2-item scale (GAD-2) and the EPDS in the current NICE guidelines. The Whooley questions are limited as they only screen for depression but this was only acknowledged by one midwife.

Barriers and facilitators associated with models of care:

Some of the more junior midwives highlighted high workload, limited time and poor continuity of carer as barriers to undertaking a thorough assessment and felt that this discouraged women from disclosing MH problems.

> *'You're trying not to sound like you're rushed but really in your head you're like oh my goodness, I've got to get through this but they just sound like they're almost being pounced on.' … 'There should be another point in the pregnancy because why would you trust me after an hour' (Both quotes: Junior midwife 009. VWT)*

> *'There's that sense of I've only got 5 minutes, please don't have anything wrong.' (Mid-grade midwife. 007. VWT)*

These challenges were not exclusive to the booking appointment and were reportedly less pronounced in the VWT. Midwives in this team felt that the increased time and continuity they had with their caseload was hugely beneficial for identifying MH problems.

> *'I don't think we have quality appointments necessarily with the women, it's different for the [VWT], you've got that' (Senior Midwife. 004 generic team) … '…we've got the luxury' (Senior Midwife. 003 VWT)*

> *'I certainly worried that by the end of my generic community experience I was almost just pattering the 'Whooley questions' off to be rushed off quickly. I think since I've done [VWT], I've realised the importance of that time to really sit with the ladies and go let's really think about this.' (Junior midwife.009 VWT)*

> *'We don't have time to actually ask and care about women. I know it's not on its own [continuity] an assessment but when you have continuity you can tell if they're themselves or not which helps. (Midwife. 005 generic team)*

Social Factors

The theme *social factors* describe features relating to the MH assessment which are dependent on people, for example: women, their friends and family, health care professionals and the general public, and includes midwives' perceptions of their role within this. In contemporary UK practice, considerable diversity is present amongst maternity populations and midwives felt that differences in personality, age, educational status, cultural and socio-economic status mean that there can be wide variations in women's comfort to share MH history and suggested that screening MH can never be infallible due to these variations.

> *'I guess the questions will work for some women but they're not going to work for everybody.' (Mid-grade Midwife. 006 generic team)*

This was thought to be true for women from Black, Asian and Minority Ethnic groups (BAME). Midwives perceived that women from BAME backgrounds could find the 'Whooley questions' invasive because culturally, depression is not necessarily recognised in the same capacity as physical illness.

> *'Some cultures just don't recognise depression in the same way that we do. It's like you just carry on' (Mid-grade Midwife.007 VWT)*

> *'Pakistani and Urdu speaking ladies, they would often come with their husbands and there is no way they would ever disclose, I don't think it was just me, it was to any midwife or doctor.' (Mid-grade Midwife.006 generic team)*

Partner or relative presence during was discussed by each group and whilst some midwives reported actively involving women's partners in discussions about emotional wellbeing, others, particularly more junior midwives reported they might avoid the questions if someone else was present to protect confidentiality.

> *'Say they've got their partner with them, does that partner even know that history and then you're getting into territory where you think well, do I bring it up.' (Junior midwife.009 VWT).*

However, one of the midwives discussed her experience of involving women's families if there is cause for concern.

> *'I remember saying to him, if you're worried about her you need to get her seen… this is obviously what midwifery is, it's family.' (Mid-grade Midwife. 005 generic team)*

This demonstrates that there are also wide disparities in how midwives' practice, their experience and comfort levels.

> *'I think midwives have different experiences, they come with different experience and they have different levels of comfort in asking those questions.' (Senior Midwife. 003 VWT)*

Whilst none of the midwives reported using any other tool to assess MH, some of the senior midwives described more instinctive methods of assessment.

> *'I think you have to kind of adapt it to the situation and where you have got somebody where you think there maybe mental health issues actually elaborate' (Senior midwife. 003 VWT)*

Despite recognising the importance of assessing MH in pregnancy, all the midwives felt ongoing management of mental illness fell outside the scope of their practice.

> *'I think once you've identified someone anyway, you are looking at a referral process as a midwife, you know that's starting to get out of your remit … at the end of the day, we're not expected to be mental health practitioners.' (Junior Midwife. 009 VWT).*

Trust

The theme of trust was central to the entire dataset and underpins several barriers affecting screening for MMH. Key features included challenges with continuity, time and workload which were also present within *system factors* and were believed to prevent women from trusting midwives to disclose MH problems. Additionally, stigma surrounding mental illness in pregnancy and the association with social service involvement was considered by the midwives to have a big impact on disclosure. The concept of trust was reciprocal, and midwives also demonstrated mistrust of women to disclose mental illness.

> *'(With continuity) you have their trust, so I think they're more likely to be forthcoming with that information or to approach you if they are concerned about something.' (Senior midwife: 003 VWT)*

> *'It comes back to that whole midwifery thing of knowing and trusting and we're so far away from that … It all comes back down to: they're going to take my baby away because I'm crazy … because it's still got a massive stigma attached.' (Mid-grade Midwife.006 generic team)*

> *'Some people fear telling us things as who are we going to share the information with, what are the consequences.' (Junior midwife. 008 generic team).*

Alongside their beliefs about why women choose not to disclose mental illness, several midwives expressed frustration and limited confidence in women to share medical and social history during antenatal booking appointments.

> *'I've had women say no I've got no mental health issues and then you can see (on the referral) that they are medicated and stuff and you think you've lied to my face' (Senior Midwife 004 generic team)*

> *'A lot of women don't do a lot of things, the screening booklet for example, that's such a good tool, so much valuable information in there and then you'll talk about it and they'll go oh no I never got given one of those. Well you did because I was your midwife' (Junior Midwife. 008 generic team)*

The 'screening booklet' referred to is given to women at the booking appointment to explain when and why screening tests are offered during pregnancy. The above statement suggests that midwives do not always trust women to be honest in response to screening in general. Midwives were not always empathic to the reasons why women may not wish to disclose and could be attributed to challenges with continuity which were presented as a greater problem for those working in generic teams. It is also possible that midwives feel emotionally fatigued and therefore appear less empathic. For midwives from both teams, trust was also linked to their concerns for missing someone who is seriously unwell and fear of serious

incidents. The concept of midwives' lack of trust in women could also be attributed to mistrust in themselves to sufficiently explore women's MH, indicating problems with confidence in MH expertise.

> *'We need more training so that the midwives feel confident to kind of broach mental health as a whole' (Senior midwife. 003 VWT)*
>
> *'I think it's also something midwives can be a bit scared of because it's what do I do with it and two, it can bring up their own issues around mental health, you know having to explore that with somebody else. And three, just that sense of you know oh this makes everything so much more complicated' (Mid-grade midwife. 007 WVT)*

Discussion

Midwives experiences:

Overall, midwives felt that assessing MMH was important but described several challenges in contemporary practice which they felt prevented an in-depth assessment. The heterogeneity of the sample meant there were differences in midwives' experiences of assessing MMH and whilst the majority described being comfortable exploring MH with women, junior midwives were less confident to fully explore women's MH. Whilst all those taking part were aware of the 'red flags' for deteriorating MH and the professional support available, they felt that managing MMH fell outside the midwifery remit, reinforcing findings from previous studies describing the need to improve midwives' preparedness to manage MH in pregnancy (Ross-Davie et al. 2006; McGlone et al. 2016). Pregnancy is a key window of opportunity to highlight MH problems and these findings, together with those from previous literature suggest more insight is required into the significant role midwives can play in safeguarding women's emotional wellbeing.

Limited time and issues with continuity were considered major factors preventing in-depth assessment and disclosure of mental illness. This is recognised at a national level and the most recent maternity services review (*'Better Births')* recommended that midwives have sufficient time with women to build mutual trust (NHS England, 2016). This report also demonstrated that both midwives and women feel that continuity enables improved recognition of problems and creates a safer service. There is robust evidence from a recent Cochrane Review investigating midwife-led care compared to other models of care, demonstrating midwifery continuity models improve outcomes and safety (Sandall et al. 2015). Whilst this review does not identify specific findings for women with mental illness, the importance of continuity for women with MH needs is well documented (Phillips and Thomas, 2015; Williams et al. 2016). Further research on a larger scale would better establish the impact of effective continuity on MMH.

Whilst we have highlighted several barriers to effective screening, trust was thought to be a key factor influencing disclosure. Women's lack of trust in the service was thought to be associated with inadequate continuity and concerns that disclosure could lead to social service involvement, which is a consistent finding from other studies (Kingston et al. 2015; Phillips and Thomas, 2015 RCOG, 2017). Time constraints during appointments mean that women feel unable to develop a rapport with midwives sufficient to disclose emotional distress (McGlone et al. 2016; RCOG, 2017). Findings from the literature and from our study demonstrate that more focus is required on provider-patient relationships and although the *Better Births* report

(NHS England, 2016) recommends continuity of carer, special consideration for this in the context of MH is required.

Mistrust was reciprocated by the midwives and although this was not exclusive to mental health screening, midwives shared a general lack of confidence in women to use resources and disclose MH history, and were not always empathic to the reason why women do not disclose. The theme of mistrust was not presented in any of the literature reviewed as part of the study and future research should explore the reasons why trust might be a problem in contemporary practice and how the relationship between women and midwives might impact MH problems.

Midwives' views of current guidelines:

The midwives described following current NICE guidelines as challenging due to the time constraints of the antenatal booking appointment, the large volume of other information to discuss and it often being the first interaction with the woman. This is supported by previous research indicating that midwives and women feel rushed during this initial appointment, limiting disclosure of mental illness (McGlone et al, 2016; Phillips and Thomas, 2015). Although midwives described both advantages and disadvantages for using the 'Whooley questions', most felt the questions were not optimal for encouraging disclosure, but had difficulty articulating whether this related to the questions themselves or to the context in which they are asked. Barriers associated with lack of time could be overcome to some extent by the use of digital technologies and evidence suggests that online self-reporting prior to the booking appointment saves time and encourages disclosure, as the anonymity associated with online reporting feels more private (Johnsen et al, 2018).

Midwives reported discomfort asking women from BAME backgrounds the 'Whooley questions', suggesting that mental illness is not always recognised in the same capacity as physical illness within BAME cultures and women may experience additional stigma in discussing MH problems. It is also possible that some of the mistrust surrounding disclosure is based on these concepts about marginalised groups. This has important relevance to assessing and managing MMH within the UK and in an international setting. Globally, MMH problems are a major public health issue and WHO development goals suggests a stronger focus on MH conditions in the delivery of care for maternal and child health (WHO, 2019). With the risk of maternal death almost five-times higher among women from black and ethnic minority backgrounds (Knight et al. 2018), the findings relating to cultural differences and MMH have important safety implications and further research is needed to understand more about ethnic differences in the context of MMH.

Strengths and limitations

The main aims of the study were achieved and the findings relating to models of care and the challenges of modern midwifery practice have important relevance to future global maternity care, in particular, the role of midwifery continuity in recognising and managing mental illness. Several steps were taken to increase the overall rigor of the study and included keeping a reflexive diary, analyst triangulation and having an impartial member of the senior midwifery team facilitate the focus groups. Lastly, the opinions of a local patient liaison committee were sought and ensured the study was relevant to service-users, as well as staff.

Several challenges with recruitment were experienced and whilst these difficulties meant the final sample size was less than anticipated, several lessons can be taken from the research process that could help to inform future research involving staff members. The main challenge was recruiting staff who had busy work commitments and subsequently organising focus groups around service provision. It was intended that groups include between four and six midwives but due to these challenges, groups consisted of two to three participants. This did not affect the primary objective of the study and saturation of data was reached by the third focus group. Despite this, there was little variation in opinion which could be attributed to small sample size, the fact the research was only carried out in one health district, or to participants giving socially desirable responses to agree with their peer. In-depth interviews may therefore have been preferable. However, some questions may also be better answered by a knowledge and practice survey and this study should now be used to inform a multi-centre, quantitative survey to increase representation.

The challenges surrounding recruitment enabled us to consider what was helpful and what, if anything hindered the process. Stakeholder involvement was key, as was the inclusion of midwife champions to encourage peers to take part. In contrast, email was generally not well responded, probably due to limited remote access for community midwives. For future research, the use of multiple sites and a longer recruitment period may strengthen sample size and improve transferability (Sprague et al. 2009).

Recommendations for practice and future research

- A key challenge experienced by the midwives was lack of time during the booking appointment. Future research should build on facilitators highlighted in this study and explore the role of continuity in encouraging disclosure, and the optimal gestation and environment to assess PMH.
- The common perception that MMH falls outside the midwifery remit suggests that improved training for midwives may be required to better prepare them to recognise and manage MMH. A greater focus on MMH in the undergraduate midwifery curriculum and midwives' mandatory training could also improve midwives' confidence to manage MH.
- The issues highlighted around trust were an unanticipated finding and raise questions about the relationship between women and midwives in contemporary practice. This requires further investigation to explore if trust is a significant factor affecting both women and midwives, particularly in the context of MMH.

Conclusions

Barriers associated with screening for MH during pregnancy mostly related to inopportune placing of the 'Whooley questions' at the end of the booking appointment and the challenges associated with this appointment. However, the importance of midwifery continuity for encouraging trust between women and midwives was a central finding from this study and appears to have significant consequences for assessing MMH. This is particularly pertinent for women from marginalised groups who were thought to experience increased MH stigma and therefore less likely to discuss MH problems. Further research is required to evaluate the impact of continuity on the relationship between women and midwives and the influence this may have on MMH.

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