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Midwives and women's views on using UK recommended depression case finding questions in antenatal care

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ABSTRACT

Objective: detecting and treating depression early on in pregnancy can improve health outcomes for women and their children. UK guidelines recommend that Midwives screen for antenatal depression (AND) at the woman's first Midwife appointment using recommended depression case finding questions. This is the first qualitative study to explore Midwives' and women's views of using these questions in the context of antenatal care. Design: Semi-structured interviews with Midwives and pregnant women exploring their views and experiences of screening for AND, conducted alongside a validation study of the depression case finding questions.
Setting: the initial appointment with the Midwife when the woman is 10–12 weeks pregnant. Interviewees were working or living in Bristol, England.
Participants: maximum variation samples of 15 Midwives and 20 pregnant women. Measurements and findings: Midwives and pregnant women viewed the depression case finding questions as a useful way of introducing mental health issues. Midwives often adapted the questions rather than using the phrasing specified in the UK guideline. Sometimes Midwives chose not to use the questions, for example if a partner was present. Both Midwives and women struggled to differentiate symptoms of early pregnancy from antenatal depression; yet thought that detecting depression early on in pregnancy was important. Women were unsure about the kind of help that was available; some women reported this as a reason for withholding their true feelings. There was a general lack of awareness among Midwives about the range of non-drug treatments potentially available to women and referral pathways to access them.
Key conclusion: both Midwives and women regard screening for AND as acceptable and important but reported shortcomings with the recommended depression case finding questions.
Implications for practice: providing training for Midwives on how to frame the questions and increase their knowledge and application of the referral pathways suggested by UK guidelines will help address some of the issues raised by Midwives and women in our study.

Introduction

To date there has been substantial research and clinical interest in postnatal depression and its detection and treatment. It is now recognised that depression frequently occurs during pregnancy, but depression at this time has received much less attention and little research on targeted interventions. The prevalence of antenatal depression (AND) is estimated to range from 6.5% to 12.9% (Gavin et al., 2005; Gaynes et al., 2005), and half of women diagnosed with postnatal depression will have been depressed antenatally (Leigh and Milgrom, 2008; Milgrom et al., 2008).

AND is particularly important as it has implications for the well-being of both the mother and fetus. It has been associated with poor clinic attendance, smoking, drinking alcohol, substance abuse, hypertension, gestational diabetes, low birth weight, prematurity and poor fetal development (Grote et al. 2010; Grigoriasdis et al., 2013; Stein et al. 2014). In addition, women who have AND, feel that it is a threat to the developing baby and have doubts about their maternal ability (Bennett et al., 2007).

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Although important, identifying antenatal and postnatal depression is not straightforward for health-care professionals. Less than 50% of cases of postnatal depression are detected routinely by primary health-care professionals (Hewitt et al., 2009). Both Midwives and Health Visitors report difficulties in detecting perinatal mental heath problems and find care between Midwives, Health Visitors and mental health services hard to co-ordinate. They also report having little knowledge of the community services available women can be referred to (Stanley et al., 2006; Jomeen et al., 2013).

The National Institute for Health and Care Excellence (NICE) (2007) antenatal and postnatal mental health guidelines recognise the need to identify AND. These recommendations were retained in the updated guidelines (NICE, 2014). They recommend that, at the first contact during pregnancy, health-care professionals ask the following two questions to identify possible depression:

During the past month, have you often been bothered by feeling down, depressed or hopeless?
During the past month, have you often been bothered by having little interest or pleasure in doing things?

The 2007 NICE guidelines recommended that a third question should be considered if the woman answers 'yes' to either of the initial questions

Is this something you feel you need or want help with?

The recommendation to use the third question has been omitted from the 2014 guidance. It was not included as it resulted in poor discrimination between true-negative and false-negative cases, which could increase the risk of depression being missed out on. There was also no clear benefit to its inclusion (NICE, 2014).

The guidelines do not specify how these questions should be asked – verbally or in written form. In the literature the first two questions are sometimes referred to as the 'Whooley' questions. These types of questions are often called depression case finding questions, case identification instruments or screening questions. For the purposes of this paper, the first two questions will be called the two depression case finding questions. The third question is not strictly a case finding question, rather an aid to help decide what to do. However, for simplicity, in this paper, we have called the two questions plus the 'help' question, the three depression case finding questions or the three questions.

The two depression case finding questions were found to be a useful 'first-step' self-reported aid for identifying depression in primary care (Whooley et al., 1997) and have also been used for depression screening in chronic diseases, such as diabetes and coronary heart disease (McManus et al., 2005). A third self-reported 'help' question (Table 1) was added by Arroll et al. (2005), which aimed to improve specificity resulting in fewer false positive cases without reduction in sensitivity when used in a primary care context.

Antenatally, Mann et al. (2012) have examined the validity of the three depression case finding questions by self-report at 26–28 weeks gestation against the DSM-IV criteria for major depressive disorder. In contrast to screening in primary care, inclusion of the 'help' question reduced the sensitivity compared to the two screening questions alone, therefore increasing the number of false negative responses, although it did improve specificity. However, there is a considerable difference between completing a written self-report questionnaire administered by a researcher as part of a study at 26–28 weeks, and the routine use of questions asked by Midwives during the booking appointment, which is the first face-to-face appointment a woman will have with her Midwife at around 10–12 weeks gestation.

There has been much research on the difficulties encountered by health professionals screening for depression in primary care, besides those, encountered by Midwives. Maxwell et al. (2013), in a qualitative study, interviewed practitioners who asked the two screening questions of primary care patients with chronic diseases to explore how clinician–patient interaction influenced the outcome of the screening process (Maxwell et al., 2013). Case-finding was sometimes asked in a way that discouraged a positive response, as the practitioner did not have the time or felt too overwhelmed to provide appropriate care. Nurses found screening to be an uncomfortable task with no immediate support or services for patients when possible depression was detected.

Similar responses may be expected of Midwives, who have many tasks to complete at the booking appointment and have little formal training in mental health making it difficult for them to support women who screen positive (Ross-Davie et al., 2006). Also, the woman's reaction to the three depression case finding questions will also have an impact on how well the depression case finding works in the clinical setting. It is unknown how women feel about the universal use of these questions in the perinatal period. There is some evidence that the use of the Edinburgh Postnatal Depression Scale (EPDS), is acceptable to depressed and non-depressed women both antenatally and postnatally (Gemmill et al., 2006; Leigh and Milgrom, 2007). However, this tool is longer and rather than being completed verbally and is completed in written form.

Despite NICE (2007) recommending that the three depression case finding questions are used at the booking appointment by Midwives, to date, no study has explored the acceptability of these questions to Midwives and pregnant women at this appointment.

The extent to which Midwives employ the three depression case finding questions, the way in which they ask them, and their acceptability to women, will influence how effective these questions are at identifying women with AND. Thus, we conducted semi-structured interviews with Midwives and women to explore their views and experiences of the three depression case finding questions at the booking appointment.

Table 1
Topic guides for Midwives and women – key domains.

Topic guide for Midwives – key domains
About yourself
Perceived role of mental health in antenatal care
Current screening practice and support for antenatal depression
Views on treatment for antenatal depression
Experience of referring women to the validation study
Topic guide for women – key domains
Personal situation and perspective on pregnancy
Experience of the booking visit
Views about mental health screening
• Recall of screening at booking
• Acceptability of screening at booking
Perspective on own mental health
Managing low mood in pregnancy
Experience of taking part in the validation study
• Recruitment
• Baseline assessment questionnaires and tasks
• CIS-R specifically

Method

The data reported in this paper were collected as part of a qualitative study carried out alongside a validation study of the three depression case finding questions (Baxter et al., 2014). The setting was the antenatal booking appointment. This validation study entailed comparing pregnant women's answers to the three