



Perinatal Psychosocial Assessment; What are the Views of Health Professionals Working in the Private Obstetric Sector?

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Abstract

Background: Women are not universally or routinely screened ante-or postnatally for psychosocial risk factors, depression and anxiety in the private sector in Australia. There are limited studies that explore health professionals' views on screening or perceived barriers to the screening process.

Aim: The aim of this study was to discuss the health professionals' views of psychosocial screening and assessment who work in the private obstetric sector.

Methods: Semi-structured face-to-face interviews were completed with 11 midwives, 1 social worker and 2 obstetricians. Three hospital sites were chosen, of which only one currently screens women for psychosocial risk factors. Thematic analysis was applied to interview transcripts. Three researchers then discussed reoccurring themes and a consensus in themes and subthemes was reached.

Results: Only one hospital was screening women and had midwives trained in psychosocial assessment including depression screening. There were mixed views on the process and barriers to screening were identified, e.g., lack of support systems, cultural barriers, inaccurate answers, power barriers with obstetricians, husband interference, fear and powerlessness. Benefits were recognized: early identification of difficulties, standardization and patient-focused care. Concerns were, however, also evident: suicide ideation, intrusiveness of questions, whether women responded honestly, not wanting to screen all women.

Conclusion: There was an identified concern by midwives that obstetricians did not take seriously any concerns highlighted by the midwife about women's psychosocial problems. There was a sense of a lack of 'ownership' of the women, therefore a feeling of helplessness in addressing their needs. Suggestions were made: appropriate education and training of midwives, flagging high risk women, more in-house resources and external resources/community links and employing a central midwife with interest and expertise in psychosocial screening.

Keywords: Psychosocial assessment; Private sector; Health professionals

Introduction

Women are not universally or routinely screened ante-or postnatally for psychosocial risk factors, depression and anxiety in the private sector in Australia. There are limited studies that explore health professionals' views on screening or perceived barriers to the screening process.

Methods

The studies conducted for this thesis were approved by the Human Research Ethics Committee (HREC) of the University of Sydney approval number, 15315. Interviews were completed in a focus group format or face-to-face. Interview questions were analyzed using thematic analysis and were verified by a second person. Thematic analysis was undertaken by identifying concepts or experiences and then combining and cataloguing the related patterns into sub-themes [1]. This process was performed by three researchers who then discussed common themes and a consensus in themes and subthemes was reached. Thematic analysis was used [2]. The style of Qualitative Analysis employed resembled that described by Burnard [1] and more recently termed 'editing analyses' by Polit and Beck [2]. As the researchers conducted the interviews, they kept field notes that were used to contextualize the data and contributed to the commencement of data analysis.

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Results

Group 1: Booking-in midwives

The midwife includes the psychosocial assessment as part of her usual antenatal clinical interview. Her role is to assess all women at booking-in for psychosocial risk factors and offer referral as needed. The booking-in visit is conducted in a private room with the woman, her partner and midwife present. The partner could be asked by the midwife to leave the room to ensure privacy.

Only those midwives who had attended the Perinatal Mental Health Assessment (Introductory Training) could participate in the study, enroll women to the study, gain their consent and conduct the screening using the Clinical Care Guideline package. During the booking-in visit, women who had consented to be part of the study were asked a series of psychological questions and also given an Edinburgh Perinatal Depression Scale to complete [3].

It is generally accepted that, in an English-speaking population, an EPDS score of 10-12 suggests the respondent may meet criteria for minor depression; a score 13-18 suggests she would probably meet criteria for depressive illness: 19-30 indicates a higher degree of distress and complexity, possibly including depressive illness, but also including other factors, such as a positive score on question 10 (self-harm). Women are offered follow-up according to established referral pathways.

Group 2: Obstetricians and other health professionals

Health professionals (obstetricians, midwives, general practitioners, social workers, psychologists, early childhood nurses) involved in delivering care to study participants as above were asked to contribute their views on the effectiveness/suitability of the clinical care guideline package following implementation, using semi-structured interviews.

Midwives and obstetricians were then interviewed in focus groups or individually to ascertain the appropriateness of the psychosocial screening questions, as well as any concerns, suggestions and other issues.

Group 3: Private hospital midwives

Interviews were commenced with midwives working at other private hospitals (in addition to the primary study site) to ascertain their views on the effectiveness/suitability of antenatal psychosocial questioning. Early detection and appropriate referral are the main aims of data collection, with a view to establishing Commercial-in-Confidence evidence for implementing routine, universal screening in this setting. Midwives at each facility (as well as those at the study site) were invited to share their experiences of the antenatal psychosocial and depression screening of women through voluntary participation in semi-structured qualitative interviews (Table 1).

Themes

Benefits of psychosocial screening

We need to know: A dominant theme among all midwives consenting to interview was related to the benefits of screening women for psychosocial issues. The midwives indicated that this type of information was not only helpful but necessary for them to give the best possible care to women.

Midwives spoke of the “need to know” to be able to provide a comprehensive service and holistic care to women. They felt the experience of questioning women offered the opportunity to ask

questions, to debrief and provide tailored care.

For example, midwives spoke of answers to the psychosocial questions giving them a “heads up” (M1) or “flags going up” (M2) or “opening things up” for further discussion.

Midwives comments; “We get the heads up that there are issues” “It is invaluable”. We can put supports in place for women, it opens things up”. It allows us to look for issues and explore them with the women” (midwife 1).

Yes, apart from looking after the body, we are looking after the spirit and mind as well. These women are not stupid: mostly career women (midwife 2). Yes,” If you don’t ask, you won’t know” (midwife 3).

Consistency: Another major sub-theme within the benefits of screening concerned the consistency of approach in asking the questions. For example, “We can display empathy for the women if we are aware of their issues”. The benefit of a consistent approach rather than self-selecting who to interview was evident, “Women are consistently asked the questions, all on the same page”. It gives them the opportunity to disclose” (midwife 5).

“It is less threatening if it is standardized”

“It helps us tailor the care to meet their needs”

Risks of not screening: Midwives were asked directly about the benefits and risks of not screening. Midwives indicated that the benefits outweighed the risks. For example: Yes, “There are no risks, only benefits, if we don’t ask and they have a history of self harms it’s our duty”. (Midwife 1) and, “No benefits in NOT asking them. If we don’t we miss someone at risk” (midwife 3). Although there was an expressed sensitivity around asking the screening questions, “However, they may be uncomfortable being asked these questions”. “If we don’t ask, we won’t know, for example-DV. We can plead ignorance if we don’t ask, as we are not aware” (midwife 4) “I’m in two minds, as some women want to disclose and others don’t. I think that they should given a choice/elect to answer the questions”. “The risk of not asking them is that they will get no help, may have prolonged PND or suicide” (midwife 5).

Barriers to screening

No training/experience in how to screen: Midwives identified a lack of training and experience in how to screen women. Only one of the three sites had received any training in psychosocial screening. For example, “Staff feeling uncomfortable and being inexperienced. There is no antenatal clinic. No staff with mental health training. An antenatal clinic would allow rapport building. Also, the husbands are present” (Midwife 3). Some midwives noted that they needed to screen regardless of their lack of training and therefore relied on experience or a “gut feeling”. “We have to rely on our experience to detect issues”. “But some of the midwives don’t have the experience to do this”.

“I think that the postnatal midwives need training, they administer an EPDS but often don’t know how to score it or what is considered high risk and when to refer”.

The husband: Some midwives highlighted the issue of the husband being present. Some husbands stayed in the room to interpret for the woman or were not asked to leave by the midwife. “The problem is that often the husbands come and we don’t ask them to leave, that’s the way we have always done it; the booking in”. “We

Table 1: Themes.

Theme	Subtheme	Quotes
Benefits of psychosocial screening	We need to know	"We would know where they are at, so that we can help them". If you don't ask, you won't know".
	Consistency	"It helps us tailor the care to meet their needs ' "The advantage is having that background information on the woman".
	Risks of not screening	"No benefits in NOT asking them. If we don't we miss someone at risk" "If we don't ask, we won't know, for example-DV".
Barriers to screening:	No training /experience in how to screen:	"Staff feeling uncomfortable and being inexperienced". "We have to rely on our experience to detect issues". "But some of the midwives don't have the experience to do this".
	The husband	"Some ladies are depressed but have domineering husbands that won't let you talk to them on their own". "Sometimes you see that the woman wants to talk, but there is nothing that you can do, as the husband is there".
	The obstetrician	"Some obstetricians just don't want to know about any issues that the women may have". "we are often left in the dark about women's problems", "we rely on the obstetricians to document but they often write nothing"
Other themes:	They lie/fear	'However, some women lie, they will talk if they want help', "The women can lie and not admit that they have problems" "A person's unwillingness to admit to issues" 'The personal nature of the questions'
	Midwife barriers	'Some questions are a bit odd: they have already been asked and the woman may not want to talk about it again. That is awkward'. Some midwives are more attuned than others. Things need to change here" (SW).
	Lack of awareness	"They are often unaware of the connection between their past history and their present status/effect".
	Lack of time	"The pressure on staff, time" "It takes time to screen the women".
	supports	"We don't have a social worker; we don't have enough supports for the women". Yes. And some already have help.
	Further suggestions	"More access to public health services would be helpful" (midwife 4) "I think that we need regular in-services/training" (midwife 1) "We need to be clear on the referral pathways to help a woman, instead of feeling lost".

have a lot of women from India who come with their husbands, often the husbands fill out the EPDS for their wives or with them, and we rely on them to interpret for the women". There was a concern expressed by midwives that they often could not speak to the women on their own as the husbands refused to leave when the woman was being interviewed.

The obstetrician: At times, the obstetrician was viewed as a barrier by the midwives in their attitudes. For example, "The obstetricians, they are often defensive", "the obstetricians, they have a sense of ownership of the women". There was also a concern that when the midwife did in fact high light a woman's psychosocial issues to the obstetrician that it was not taken seriously. "Sometimes they fob you off when you identify an issue and alert them- the obstetricians", "We are often left in the dark about a woman's problems", "We rely on the obstetricians to document but they often write nothing".

Other themes

They lie/fear: There was a reported concern by midwives that women were not honest with the results of questioning. For example, 'However, some women lie, they will talk if they want help', "The women can lie and not admit that they have problems" (midwife 1). Woman may also fear any potential consequences of disclosing issues, "Some women don't want to know about community services as there is a fear attached, i.e., DOCS (FACS)", "They hide their issues, some come here to hide from DOCS, they come under a false name and don't want to go to the public system because of DOCS". This is referring to FACS-Family and community services who have to capacity to remove the baby from the mother).

They don't want to disclose- the women, they are high powered 38 to 40 year old women that often run big businesses/are high flyers and are used to being in control".

Midwife barriers: Some midwives expressed concern about the psychosocial questions. "Some questions are a bit odd: that is

awkward' (Midwife 2). There was also concern about discomfort in asking the questions or receiving uncomfortable answers, difficult responses include: mother passed away; patient estranged from family; half a dozen said abused as a child; someone with trauma in first delivery so has come to private hospital this time; infertility; lack of support. Interestingly some midwives indicated that they could either determine which women warranted asking the psychosocial questions, or that women should indicate that they wanted to be screened. "I don't think that we should screen all women, the odd one may say that they wanted to be asked the questions".

A social worker expressed concerns with the booking-in process at a hospital. "Certain midwives are more receptive to assisting women than others. Most women here don't seem to disclose at booking in. I get the majority of referrals postnatally when they stay for 3-4 days and a more attuned midwife picks up that there might be a problem. Things need to change here" (SW). The answer- "Change the booking in midwife and educate the midwives.

Lack of awareness: Another sub-theme indicated a concern that women were neither attuned to the psychosocial questions nor understood their relevance, "They are often unaware of the connection between their past history and their present status/effect".

Language can be a barrier, e.g., some Asian women: a few women are very business-like (midwife 2).

Lack of time: Time was seen as an additional pressure in psychosocial screening. "It takes a long time to screen the women" (midwife 1). "They book in online" "The pressure on staff, time" (midwife 5).

Enough supports

A subtheme emerged around a lack of resources and supports for women once positively screened. "We don't have a social worker; we don't have enough supports for the women". When asked

whether there was enough support for women one midwife replied, “Sometimes you need to call the obstetrician several times before something is done to help the women, but you just need to keep onto them, the obstetricians”.

General comments

“The psychiatrist may retire soon and I don’t know if she will be replaced” (midwife 4).

We only have 1 useless psychiatrist and 1 social worker; they help a bit at least” (midwife 3).

”We need better follow-up”

“We can’t refer; we just let the obstetrician know”

“We do follow-up with the child and family health nurse and flag women if we are concerned”

Further suggestions about the psychosocial screening process/procedure?

As mentioned by the NUM, it would be good to talk to the women more postnatally, including debriefing (midwife 2).

“Ongoing support/training so that staff can repeat the EPDS”. We need an update” (midwife 3).

“More access to public health services would be helpful” (midwife 4).

“Sometimes the fathers look depressed; I suppose we could also give them an EPDS?”

“I think that we could re-administer the EPDS during antenatal classes at 32/40 approx, as often concerns come up in the classes. These concerns may not have been there at 12-20 weeks when we book them in”.

“Our midwives are older here and attuned to women’s needs due to their life experience, they have been there, done that, had their families” However, the postnatal midwives would not know how to score; use or flag an EPDS score so need training”.

“If we are concerned postnatally we often ask the husband what the woman is normally like”

“We need a social worker, just for this unit”

“We need a community link for the women”

“We need to be clear of the referral pathways to help a woman, instead of feeling lost”.

“The antenatal classes may be an opportunity to educate the women about psychosocial issues, however, we have such a poor

attendance at these classes, as women view them as only for a woman wanting/booking in for a natural birth, not a C/S. Midwives in the obstetricians’ rooms could screen/support the women also. The women need to book in earlier and if they are identified as at risk we could see them again” (Midwife 3).

Discussion

At the time of the study, only one other private hospital in Sydney was screening women and their midwives were trained in psychosocial assessment. There were mixed views on psychosocial screening and barriers to screening were identified. Benefits were also identified: early identification of problems, standardization and patient-focused care. However, midwives also expressed concerns: suicide ideation, intrusiveness of questions, “some women lie”, not wanting to screen all women, lack of support systems, cultural barriers, and inaccurate answers, power barriers with obstetricians, husband interference, fear and powerlessness. Relevant suggestions were made: appropriate and adequate education, training and support of midwives; flagging high risk women; more in-house resources and external resources/ community links, and employing a central midwife with interest and expertise in psychosocial assessment and screening. Midwives had various views on the program. Some felt that it was within their work role, others did not. Some were fearful of what could be revealed by the woman and how to deal with it. There was an identified concern that obstetricians did not take seriously any concerns highlighted by the midwife about a woman’s psychosocial difficulties. There was a sense of a lack of ‘ownership’ of the women, therefore a feeling of helplessness in addressing their needs. Some midwives indicated an interest in a woman’s perinatal mental health/psychosocial risk factors; however others expressed a concern that this was not part of their role. This highlights the need to educate and support midwives working in the private sector on their important role in enhancing the perinatal mental health of women in their care. Their role includes potential for prevention, early intervention and health promotion to benefit not only the woman but her child, partner and family.

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