The Perinatal Journey:
The process and impact of psychosocial assessment

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DEDICATION

I would like to dedicate this thesis to the 34 women who shared their personal stories and experiences of psychosocial assessment and depression screening during their pregnancies and after the birth. The midwives and child and family health nurses (CFHNs) who agreed to have me present observing clinical practice and who shared their experience of this very sensitive and emotional work. It was a very humbling experience to feel that the women, midwives and CFHNs were willing to trust me and share with me their personal stories. I would also like to dedicate this research and its findings to the many women who have suffered or experienced mental health issues during pregnancy or after birth and to families affected by these unfortunate life events. Let us hope that through more research, of this important area of health and wellbeing, we can gain more awareness as a community of the issues and prevent further suffering.
ACKNOWLEDGEMENTS

I extend my deepest gratitude to my dear family, friends and colleagues who gifted me their many talents along this journey. Be it music to soothe my soul; open hearts in support; a sharing of experience in empathy and a constant ‘you can do it’ attitude - for this I am truly grateful.

A special note of thanks to my supervisors; Professor Virginia Schmied; Associate Professor’s Lynn Kemp and Tanya Meade; whom taught me various lessons along the way, generously sharing and imparting their knowledge and expertise assisting in the fruition of this important research and thesis. Thanks to our research partners, Karitane, particularly Robert Mills, Professor Bryanne Barnett, Monica Hughes, Jane Kohlhoff and Deborah Nemmeth. A special thanks to fellow students and colleagues for the camaraderie and support throughout.

Most of all, my sincerest thanks to all the participants who made this study possible, the midwives, child and family health nurses, and the women. Your generosity enabled this research to be conducted and your openness and honesty enriched my understanding of your experience.
STATEMENT OF AUTHENTICATION

The work presented in this thesis is original to the best of my knowledge and belief, except where acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

...........................................

(Mellanie Rollans)
OUTCOMES OF THIS THESIS

This thesis is presented as a series of four papers (*published, accepted and in press etc*). I am the first author of each of the papers and had full responsibility for collecting and analysing the data reported in each paper along with the development of an observation tool (4D&4R). I prepared the drafts of each paper and my co-authors and supervisors provided feedback on each draft. Co-authors’ and supervisors’ contributions included assistance in designing the study, participating in data analysis and input into re-drafting or extending background material and discussion of the findings in each paper.

Publications


Conferences / Presentations


the Future. The Royal Hospital for Women's Annual One day Midwifery
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challenges in psychosocial assessment and depression screening. Seminar Health
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this one…’ approaches by midwives to psychosocial assessment and depression
screening in the antenatal period. ACM – NSW Branch Inc. Annual State
Conference, Sydney. (Oral presentation)

Challenges: in routine psychosocial assessment and depression screening.
Mothering: Challenges change and hope, University of Western Sydney. (Oral
presentation)

study of psychosocial assessment and depression screening with women in the
perinatal period: the methods used across cultures. The International
Transcultural Nursing Conference, Manipal University, India. (International
invited speaker)

approach to detecting mental health problems in pregnant women. The Annual
The Mental Health Services (TheMHS) Conference, Adelaide. (Oral
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experiences of psychosocial assessment and depression screening conducted by
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GLOSSARY AND ABBREVIATIONS

CFHN: Child and Family Health Nurse

DG: Discussion groups

ECC: Early Childhood Centre

EDS: Edinburgh Depression Scale

EPDS: Edinburgh Postnatal Depression Scale

FN: Field note

LHD: Local Health District

MR: Mellanie Rollans

NSW: New South Wales

SFE: Supporting Families Early package

UHHV: Universal Health Home Visit

VS: Virginia Schmied
ABSTRACT

The importance of early identification of women with psychosocial risk factors, such as child sexual abuse, substance use and domestic violence during pregnancy and after birth has gained significant recognition both nationally and internationally. Policy and guidelines, such as the Supporting Families Early (SFE) package in New South Wales (NSW), Australia, have been developed and recommend that psychosocial assessment be conducted by midwives and child and family health nurses (CFHNs). The purpose of this ethnographic, qualitative study is to examine and understand the meaning midwives, CFHNs and women make of the process of psychosocial assessment and depression screening undertaken during pregnancy and following birth. Specifically, this study describes and examines how midwives and CFHNs approach and deliver the psychosocial assessment questions; and their experiences and perceptions of the assessment process. This study sought to understand women’s experience of being asked the assessment questions.

Thirty four women, 18 midwives and 13 CFHNs participated in this study. Participants were recruited from two different settings in NSW, Australia. Data were collected through observations of the interactions between the women, midwives and CFHNs during assessment and screening. An observation tool (4D&4R) and field notes were used to record observations of the assessment and screening process. Following the observations, face to face interviews were conducted with the women, midwives and CFHNs. Approximately 60 Midwives and 70 CFHNs also agreed to participate in discussion groups, reflecting on their experiences and perceptions of the assessment and screening process.

The findings presented in this thesis, including three published papers, demonstrate that midwives and CFHNs in this study experience tensions in
conducting assessments, which may influence how questions are delivered. A flexible approach to assessment was preferred whilst incorporating structured tools into the process, however, some of the CFHNs in this study rejected the use of structured tools. A relationship based approach was common, developing rapport with the women to establish comfort prior to asking psychosocial assessment questions. Midwives and CFHNs utilised other skills such as observation, and drawn upon to inform their clinical judgement as to a woman’s propensity to be at risk of social and emotional distress. The tensions midwives and CFHNs experienced conducting assessment may be partially explained by the varying interpretations of the NSW SFE policy recommendations.

Overall, the women perceived the assessment questions were important, however, some women experienced discomfort, surprise and felt unprepared to be asked these questions. Women who disclosed previous negative life events, such as child sexual abuse were distressed by this experience and appeared to comply with the assessment process. In this study partners who attended the clinic with the participating women were excluded from part of or the entire visit. Women reported in interviews, that their partners had a sense of what was being discussed in their absence and provided support to women who were distressed following disclosure.

Effective delivery of assessment and screening requires ongoing education, training and supervision in the use of structured tools and how to best incorporate these into a relationship-based approach. Women could be better prepared prior to the assessment and may experience less distress if their midwife or CFHN responds with sensitivity and care. This study is part of a larger study funded by an Australian Research Council (ARC) linkage grant, in partnership with Karitane and was completed by me on a full time scholarship over three years. This thesis is presented as a series of four publications.
CHAPTER 1: INTRODUCTION

Poor maternal mental health can have a lasting impact on the mother-infant relationship and consequently the development of the infant (Misri and Kendrick, 2008). In both Australia and the United Kingdom, mental health disorders are one of the leading causes of maternal morbidity and mortality (Hayes, 2010). Up to 15% of women are likely to experience a new episode of major or minor depression from conception up to 12 months postpartum (Gavin et al., 2005). This problem is critical for maternal mental health; along with drug dependency issues and domestic violence it is recognised as a significant public health (Johnson, 2012, Thornton et al., 2006, Austin et al., 2005).

Psychosocial risk factors such as previous mental health problems, childhood abuse, domestic violence and lack of social support are associated with poor perinatal mental health (Buist et al., 2007). As a woman’s risk factors increase so does her propensity to develop depression in the future (Boyce and Hickey, 2005). The early identification of potential risk factors in women who are currently unwell or at risk of developing mental health issues, most often relies upon detection by primary health clinicians (Barnett et al., 2005, Karatas et al., 2009).

Significant efforts have occurred, both nationally and internationally, to redesign and strengthen services provided to pregnant women, children and families, particularly those experiencing distress and/or those ‘at risk’ of poor physical health and social and emotional outcomes. There is emphasis on multiservice systems and an integrated approach from universal primary, secondary and tertiary services. For example, policies such as Sure Start (UK), Healthy Families (America), Families New South Wales (NSW) (Australia) and Best Start Victoria have been implemented over recent years.
Since the late 1990s a progressive implementation of assessment and screening for risk factors for mental health problems has taken place. Integrated Perinatal and Infant Care (NSW Department of Health, 2003), now known as Safe Start (Health, 2009), is a framework guiding the practice of clinicians and primary health care professionals in the promotion, prevention, early intervention and treatment for mothers, infants and their families in NSW. This model of care integrates psychosocial risk assessment and depression screening with routine physical care during pregnancy and two years following birth. It provides a coordinated network of support and health-related services in the antenatal and postnatal periods for mothers, infants and families. Further recommendations in NSW regarding assessment and screening process were released in the Supporting Families Early (SFE) package (Health). The SFE package incorporates the Safe Start policy and guidelines on the universal implementation of psychosocial risk assessment and depression screening as part of a comprehensive health assessment in the antenatal and postnatal periods (Health).

The psychological and social model of perinatal mental health problems; which is reflected in the above initiatives, shifts assessment, intervention and support from a biological explanation of perinatal mood disorders to consideration of the impact of life events (Boyce, 2003). It places greater emphasis on health professionals such as midwives, CFHNs and general practitioners, to provide universal and primary care services as the frontline clinicians. Denoting these practitioners as aware of concurrent social and emotional risk factors and indicators of mental health concerns during pregnancy and after birth (Buist et al., 2006a). If psychosocial risk factors can be identified early in the antenatal period this may
provide opportunities to prevent mood disorders during pregnancy and following birth (Karatas et al., 2009).

International and national studies have investigated the use and acceptability of routine psychosocial assessment and depression screening in primary health care settings (Leigh and Milgrom, 2007, Buist et al., 2006b), (Matthey, 2005). However, there has been little research and evaluation of psychosocial assessment and how midwives and CFHNs conduct assessments or what impact assessment has on women’s experience. The integration of assessment and screening into routine clinical care in the perinatal period has been debated (Matthey et al., 2004) primarily in relation to the sensitivity and specificity of the tools used that is their effectiveness in adequately detecting depression (Yelland, 2009). For example, Barclay and Kent (1998) argue that the tools lack concern for specific issues affecting women and (Matthey and Ross-Hamid, 2011) asserts that the recommended cut-off scores are inadequate in detecting mental health concerns.

Further, concerns have been expressed about the process of universal psychosocial assessment and depression screening, particularly about the varying approaches used (Yelland, 2009, Hegarty et al., 2007) and the skills of midwives and CFHNs to conduct the assessments (Marron and Maginis, 2009). For example; Barclay and Kent (1998) argue that the EDS screening tool places greater emphasis on the medicalisation of what may be, for some women, a response to a change in routine and adjustment to a new lifestyle with a newborn. Barclay and Kent (1998) argue that these tools lack concern for specific issues such as isolation and support experienced by new mothers. Matthey et al. (2006) challenges the use of the EDS cut-off scores suggesting that they do not adequately represent the true nature of predictors of depression with 50% of women scoring above the indicated score for
symptomatology. Matthey and Ross-Hamid (2011) suggests that the practice may be potentially ‘over pathologising motherhood’, as most women experience transient distress adjusting to their new circumstances and that they require further assessment if their distress endures.

1:1 Aim of the study

The purpose of this ethnographic study was to examine and understand the meanings midwives, CFHNs and women make of the process of psychosocial assessment and depression screening undertaken during pregnancy and early parenting.

1:2 Background to the study

Perinatal mood disorders and distress are experienced by many Australian women in pregnancy and after birth. It is important to understand the extent of perinatal mental health and its impact on the health and wellbeing of infants and young children as well as on women and families (Priest et al., 2008). Studies in neuro-science, epidemiology and longitudinal studies of child health (Misri and Kendrick, 2008, Gunnar and Fisher, 2006, Glaser, 2000, Shonkoff and Phillips, 2000) emphasise that events during the prenatal period and in the early years of life, and the quality of care received during this period, strongly influence early development (Robinson et al., 2008, McCain and Mustard, 2002) and adult life (Shonkoff and Phillips). It is recognised that children of depressed parents are more likely to display social, emotional and behavioural problems and go on to develop depression (Sanders, 2006).

There are known, identifiable risks for poorer maternal and/or infant and child outcomes (Murray et al., 2003) from undiagnosed depression or unidentified
social problems. An Australian study of over 40,000 women confirmed the importance of the following potential risk factors: mental health problems (prior and current), domestic violence (DV), substance misuse, past history of abuse, anxiety, lack of support, separation, unemployment, lower socio-economic status and a stressful pregnancy (Buist and Bilszta, 2005, Priest et al., 2005). In contrast to the research on risk factors, there is less research around protective factors impacting on maternal and infant outcomes. Identified potential protective factors are: appropriate social support, good physical and mental health, adequate self-esteem, adequate social and economic circumstances, an uncomplicated delivery, and a healthy infant and maternal attachment (Edwards et al., 2008, Priest et al., 2005). When identified as ‘at risk’ and offered appropriate support services, the effects of these risks on maternal and child outcomes can be ameliorated.

1:3 Psychosocial assessment and depression screening in the international context

There is growing international interest in identifying women and families who are more likely to experience psychosocial distress and depression in the perinatal period. In the UK, two reports, released in 2002 and 2004 following a Confidential Enquiry into Maternal and Child Health, identify suicide as the leading cause of maternal death (Weindling, 2003). These reports highlight that women suffering from mental health problems in the perinatal period are likely to take their own lives. It was recommended that policies and protocols, such as routine screening for depression, be instituted to identify women at greater ‘risk’ and to provide information to assist when mental health issues are identified (Weindling). In response, the National Institute for Health and Clinical Excellence (NICE)
implemented guidelines in 2003, that have been revised to include the identification and management of women with psychosocial problems and depression in hospitals and in primary health care settings (Excellence, 2007).

Many maternity units in the UK have implemented a routine set of questions (Whooley questions) in an attempt to detect women’s mental health concerns and their needs (Paulden et al., 2009). The Whooley questions consist of two screening questions to be asked at the woman’s first contact with primary care, the booking visit, and twice following birth (Excellence, 2007). The questions used by primary care providers are intended to improve detection of depression in women (Whooley et al., 1997). However, (Rowan and Bick, 2008) highlight that although the screening of women may lead to early identification of mental health concerns amongst women; one of the barriers identified was the accessibility of mental health services for women with high risk mental health concerns. The other identified barrier to effective screening and provision of services was that although midwives were assessing and screening women at the antenatal booking this was not consistently repeated at subsequent visits. During the revision of the NICE guidelines in 2007, changes were instigated to “…now recommend that women with current or previous mental illness are asked about their mental health at all subsequent contacts…” (Rowan and Bick, 2008, p.81).

A further initiative in the UK was the implementation of the Sure Start Program which identified health services as the gateway to other support and intervention services and a way of accessing families with complex needs. In addition, it was found that vulnerable families were likely to be seen and assessed by health visitors, as the health visitors were known and respected members of communities (Glennie, 2005).
Similarly in the United States of America (USA), the recognition of the high incidence of distress and psychosocial needs in women and families has prompted various States in the US to develop legislation, such as in the State of Illinois, where a Perinatal Mental Health Disorders Prevention and Treatment Act was introduced. This Act articulates that all women should be invited to complete a tool to screen for depression, both in the prenatal and postnatal periods up to when the infant is one year old, and, where possible, be provided with information about perinatal mental health disorders (Maram, 2007). In the USA, Healthy Start, a nationally funded program, exists for families with young children living in communities with high levels of infant mortality and morbidity. In this program, women who have been identified by maternity services as having high risk psychosocial needs, are referred to case managers who administer the Edinburgh Postnatal Depression Scale (EPDS/EDS) to these women during pregnancy and in the postnatal period (Henshaw, 2005).

1:4 The Australian context

In Australia, the federal government funds health services but the states and territories administer and provide those services at a local level. This means that each state and territory has specific responsibility for policy in their own jurisdictions and can determine the best approaches to screening and pathways of care. Consequently approaches vary across states and territories. The following review will mainly focus on NSW initiatives and the historical development of current policy, as this is the context for the research undertaken and reported in this thesis.

The Supporting Families Early (SFE) – Safe Start policy package implemented in NSW comes in response to requests from Australian clinicians,
researchers and state health departments to standardise psychosocial risk assessment and depression screening tools and process that have been previously trialled (Yelland, 2009). This policy and clinical guidelines sits within the national framework outlined in the Australian Mental Health Plan (1998-2003) that focuses on the promotion, prevention and early intervention of mental health, with particular application in the perinatal period (Austin 2003).

In NSW the Integrated Perinatal and Infant Care (IPC) strategy was developed in the late 1990s and was the precursor or trial of assessment process that led to the development of the SFE package. IPC was designed as a model of assessment, prevention and early intervention to identify and support the mental health and physical needs of women and infants during pregnancy and after birth (Barnett et al., 2005, Austin and Lumley, 2003, Austin, 2003a, Yelland, 2009).

This model of assessment and screening was trialled in a number of NSW hospitals between 2000 and 2003 (Austin and Lumley, 2003). Midwives were provided with training on the assessment process and use of the EDS as well as screening for domestic violence. In some trial sites but not necessarily all, midwives were offered training in family partnerships and were also provided with clinical supervision (Schmied et al., 2008).

In 2004, IPC or similar approaches such as the Psychosocial Risk Assessment Model (Priest et al., 2008), were incorporated into routine antenatal clinical practice in a number of local districts. This service development required the establishment of care pathways to ensure that women with identified needs were provided or offered services, for example mental health services, drug and alcohol services (Karatas et al., 2009).
With the release of the Supporting Families Early policy and the Safe Start guidelines in NSW, psychosocial assessment and screening for depression is now recommended in the antenatal period and is being implemented across NSW (Health, 2009). In light of some critique within Australia and internationally (Yelland et al., 2009, Buist et al., 2007, Hegarty et al., 2007, Matthey, 2005) discussed below, Safe Start emphasises that assessment procedures and depression screening tools are used only to identify symptoms of maternal distress and the presence of psychosocial risk factors. The screening and assessment tools are not intended to predict specific disorders or to take the place of formal assessment of a clinical disorder by specialised staff (Austin, 2003a). The psychosocial assessment and screening process is intended to identify a woman’s social and emotional support requirements and link women into a coordinated network of support and health-related services in the antenatal and postnatal periods for mothers, infants and families (Health, 2009).

Further to the Health Department’s initiatives surrounding social and emotional assessment of women, in 2002 the Beyond Blue National Depression Initiative began evaluating the benefits of perinatal depression screening and various early intervention programs (Austin, 2003a). In 2011 the Beyond Blue initiative produced national clinical practice guidelines for depression and related disorders (Buist and Bilszta, 2005). These guidelines place an emphasis on clinicians asking psychosocial assessment questions, developing rapport and encouraging the adaptation of questions to suit an individual’s needs.

Despite the introduction of SFE package – Safe Start policy in NSW and the recommendations made in the clinical practice guidelines for perinatal mental health (beyondblue, 2011), to date there appears to be no standard national or international, approach to assessment and screening. Although clinicians, researchers and policy
makers do not underestimate the importance of the early identification of women in need, the uptake of assessment and screening process has been slow in some local health district areas (Fisher et al., 2012a). Debate remains around the structured psychosocial assessment and depression screening process, whether it should be incorporated into routine clinical practice and if these process lead to greater detection of depression and to improved treatment and to better health outcomes for women, infants and families (Matthey, 2005).

1:5 The process of psychosocial assessment and depression screening

In NSW, the psychosocial assessment and screening process incorporates a number of assessment tools that are used to identify psychosocial risk factors particularly domestic violence and antenatal distress or possible depression (Johnson, 2012, Austin and Lumley, 2003). Depression screening includes the use of Edinburgh Depression Scale (EDS antenatal) and Edinburgh Postnatal Depression Scale (EPDS postnatal) and psychosocial assessment includes screening for domestic violence, alcohol and substance misuse, stressful pregnancy, social support systems, socio-economic status, history of child abuse or neglect and previous or existing mental health issues (Matthey et al., 2003).

The SFE package recommends that routine assessment of psychosocial risk factors and depression screening be conducted by midwives and CFHNs, and that it be incorporated at two points during the perinatal period (Health, 2009). This assessment is undertaken by midwives at the first antenatal appointment (around 12 to 14 weeks gestation) and by CFHNs within the first six to eight weeks after birth.

The midwife conducts the first psychosocial assessment and depression screening at the antenatal booking visit, which is usually the woman’s first contact
with maternity services. This involves the midwife completing a structured interview using the interview questions that are embedded in ObstetriX, a computerised database used by professionals to record all information relating to the woman’s medical, including mental health, obstetric, and psychosocial history (Henshaw, 2005). The woman is asked to complete a paper-based form, EDS, which is a 10 item self-report measure used to determine the presence of depressive symptomatology (Matthey et al., 2006). This is often the woman’s first experience of disclosing sensitive information about her emotional and social wellbeing (Chew-Graham et al., 2009) and it occurs at a time that service expectations and therapeutic relationships are yet to be established with maternity staff (McCourt, 2006).

Psychosocial assessment and depression screening is repeated by the CFHN within the first six to eight weeks of discharge from hospital following birth (Mollart et al., 2009). This assessment often occurs in the home environment at the Universal Health Home Visit (UHHV) or when the woman visits the Early Childhood Health Centre (ECC). Roggman (2001) suggest that little is known about the process and the context of psychosocial interventions that occur in the home due to the private nature of the environment.

There are limited studies that have explored or evaluated the process of psychosocial assessment and depression screening both nationally and internationally. The NSW Ministry of Health has undertaken an evaluation of Safe Start but the outcome is not yet available. Further research is crucial given the federal government’s commitment to support the implementation of the National Action Plan, which includes the SFE package, incorporating the assessment of all pregnant women and new mothers for risk factors associated with poor mental health (Yelland, 2009).
The purpose of this ethnographic study was to examine and understand the meanings midwives, CFHNs and women make of the process of psychosocial assessment and depression screening undertaken during pregnancy and early parenting. Data collection includes observations of the interactions between midwives, CFHNs and women during the assessment process and follow-up face-to-face interviews. Discussion groups were held to understand the midwives’ and CFHNs’ experiences and perceptions of assessment process. The objectives of this study were to:

- Describe the approaches (actions and interactions) that midwives and CFHNs take to psychosocial assessment and depression screening.
- Examine midwives’ and CFHNs’ experiences and perceptions of the assessment process.
- Explore women’s experiences of being asked these sensitive and intimate questions - and how this influences their responses.
- Identify how the dynamics of these interactions facilitate or hinder the assessment and screening process and the potential for women to engage in ongoing support services or interventions.

1:6 Significance of the study

As this study is the first to comprehensively examine the process and impact of assessment and screening the findings may have significant implications for the potential national roll out of the Perinatal Mental Health Plan. The Australia wide implementation of this plan is supported by the federal government and the beyond blue program as part of the National Action Plan. It aims to implement routine assessment and screening of pregnant women and new mothers, however little is known about its impact. This study examines and articulates the approach taken by
midwives and CFHNs in psychosocial assessment and the engagement of women and families, particularly those that are distressed or considered ‘at risk’. The study enhances understanding of the experience and perception of midwives and CFHNs who are undertaking assessments.

Some authors (Mollart et al., 2009, Schmied et al., 2008, Kruske et al., 2006, Barclay and Kent, 1998) believe that midwives and CFHNs are inadequately prepared to undertake this type of assessment, receive little support currently and have limited skills in eliciting and responding to sensitive information and the needs of women and families. This study will assist in identifying the support and education that may be required for midwives and CFHNs to continue to undertake effective assessments. The findings will benefit women who present to the antenatal booking visit or access postnatal services where assessments are conducted, by further understanding women’s experiences of psychosocial assessment and the meanings they attribute to this process. This study will assist understanding of the factors that facilitate or hinder the assessment process.

1.7 My background

I am a mental health nurse with 20 years of experience, primarily establishing acute and community mental health services for children and young people, perinatal and infant mental health. As a health service manager, I was responsible for the implementation of the SFE package - Safe Start policy in a local health district in NSW. This role included developing service system supports for midwives and CFHNs and conducting assessment and screening process and early intervention strategies for families who experiencing high psychosocial needs. I am an advocate for the promotion of early intervention strategies that optimise the wellbeing of
women and families and for those that demonstrate a positive impact on child development outcomes.

1:8 Overview of thesis

This study investigates the process and impact of psychosocial assessment and depression screening as conducted by midwives and CFHNs at women’s booking visit in the antenatal clinic and after birth at the first home visit or six-eight week baby check (Chapter 3). The thesis consists of an overview of the literature (Chapter two), four publications (Chapters four, six, seven & eight) that present key findings, the environmental context that assessment processes take place (Chapter 5), some additional, unpublished findings (Chapter nine) and overall discussion and recommendations chapter (Chapter 10). This researcher conducted all reported interviews and observations, prepared and analysed the data and drafted the four publications. The supervisors guided me across all stages of the study and contributed to the finalisation of publications.

Chapter one, the introduction, provides a rationale for the study, an overview of the incidence of social and emotional issues in women and the impact on infants, the context of the process of psychosocial assessment within Australia and policy development. The aims, significance of the study and the researcher’s position in the study are also addressed.

Chapter two presents an overview of literature that relates to psychosocial assessment and depression screening. It covers topics such as current practice issues including the adequacy of assessment tools and service pathways, skills required by professionals, the timing of and having the time for assessments. This chapter provides a review of literature regarding women, midwives’ and CFHNs’
experiences and the approaches taken. A summary is included about the study and objectives.

Chapter three, details the methodology and methods, outlines the ontological and epistemological underpinning for the study and details the approach to data collection and analysis. It also includes ethical issues and my reflections on the data collection process.

Chapter four presents publication one which describes the process of developing an observation tool (4D&4R) for real time observations conducted in this study. Key domains were identified to provide reference points for observation during the interactions and were used to assist in the analysis of the observational data. The publication titled Capturing clinician – client interaction: development of the 4D&4R observational tool was published in Nurse Researcher (2013)

Chapter five presents a description of the environmental context, with regard to the design and layout of the environments, in which the antenatal and postnatal observations took place and possible impact on the clinicians’ or women’s experience. In this chapter my reflections as a researcher, are also presented as an important aspect of ethnographic methodology.

Chapters’ six, seven and eight present published papers of findings from this study. There is also some repetition of literature, methodology and methods according to specific journal requirements. Style, structure and content of each paper are in accordance with the guidelines of each journal the papers were submitted to.

Chapter six presents publication two, the key themes describing the process of psychosocial assessment and depression screening undertaken by midwives at a woman’s booking visit. These are described in stages: ‘The greeting’, ‘Delivery’ and midwives’ ‘response’ to positive answers. The manuscript titled, 'We just ask some
questions...' the process of antenatal psychosocial assessment by midwives., was published in *Midwifery* (2012).

Chapter seven presents **publication three** and examines CFHNs’ approach to conducting the assessment and screening process. The major themes were: ‘Engagement: getting that first bit right’, ‘Doing some paperwork’, ‘Creating comfort’ and ‘Psychosocial assessment: doing it another way’. The publication, titled *Negotiating policy in practice: child and family health nurses’ approach to the process of postnatal psychosocial assessment*, was published in *BMC Health Services* (2013).

Chapter eight presents **publication four** relates to the women’s experience of being asked the psychosocial assessment questions; and how the women perceived the midwife’s or CFHN’s approach and style. The first three themes relating to the women’s experience are titled; ‘Unexpected – a bit out of the blue’, ‘Intrusive – very personal questions’ and ‘Uncomfortable – digging over that old ground’. The impact of the midwives’ and CFHNs’ approach is reflected in the two key themes; ‘Approach: sensitivity and care’ and ‘Being watched’. The publication, titled *‘Digging over that old ground’: an Australian perspective of women’s experience of psychosocial assessment and depression screening in pregnancy and following birth*, was published in *BMC Women’s Health* (2013).

Chapter nine reports **further findings** from the study that, due to journal formats; could not be included in the four publications but are important to understanding the process and impact of screening. This chapter has not been prepared for publication but I felt it was important to report further challenges that midwives and CFHNs face when incorporating assessment process into clinical practice that were revealed during analysis. This chapter includes four parts: **Part 1:**
Midwives’ and CFHNs’ perceptions and experiences of psychosocial assessment and screening; Part 2: The experience of women from different cultural backgrounds; Part 3: Support for psychosocial assessment and depression screening; Part 4

Partner involvement: negotiating policy requirements regarding the presence of others during assessment.

Chapter ten, the Discussion, synthesises the findings reported across the four publications, including the further findings (Chapter nine) and discusses them with reference to existing literature, new knowledge and implications for midwifery and nursing practice, education and policy development.
CHAPTER 2: Literature review

2:1 Introduction

In this chapter an overview of the relevant literature is provided. With the focus on the availability of adequate resources and service pathways (Buist et al., 2007); the adequacy of current tools used in assessment (Barclay and Kent, 1998) and screening and whether midwives and CFHNs have the skills required to undertake the assessment (Hegarty et al., 2007). Clinicians have questioned the impact of the assessment process on the relationship between the health professional and the woman and her family (Kardamanidis et al., 2008) and whether there is a risk that this process of ‘surveillance’ and is over pathologising motherhood (Matthey and Ross-Hamid, 2011, Appleton and Cowley, 2008, Cowley et al., 2004). There is also a concern that the process of assessment and screening may be overburdening health professionals resulting in tensions in fulfilling policy requirements (McCourt, 2006). These concerns and issues are discussed in the following sections.

2:2 Factors that facilitate / hinder the process of psychosocial assessment

2:2:1 Adequacy of screening and assessment tools

Previous studies of routine psychosocial assessment and depression screening have not yet identified a definitive or valid tool or measure to be used to identify those women who are most at risk of psychosocial or mental health concerns (Johnson, 2012, Priest et al., 2008). The assessment and screening tools used in routine clinical practice are intended to identify women who are experiencing distress and the presence of psychosocial risk factors, but do not predict the presence of clinical disorders (Priest et al.). Examples of self-report measures include the Antenatal Risk Questionnaire (ANRQ) which suggests fields for the identification of risk factors
Self-report measures are recommended for use in combination with the EDS (Priest et al.) and some are found to be useful for staff and acceptable to women when asked (Buist et al., 2006b, Matthey et al., 2004). Although, the ANRQ, for example, was found to be highly acceptable to women (Austin et al., 2013), currently it is not a recommended assessment tool for measuring perinatal risk (Johnson).

A recent Cochrane review by Priest et al. (2008) showed that a concurrent measure of potential risk factors and emotional status in combination with raising the awareness of staff of potential risk factors increases the detection of risk and symptomatology in pregnancy. The multi-component approach to psychosocial assessment was evaluated by testing the Psychosocial Risk Assessment Model (PRAM) (Priest et al.), incorporating two self-report measures to identify symptoms of distress and psychosocial risk factors, the EDS and the ANRQ. During the development and use of the PRAM model, women attending the antenatal clinic (2002-2005) presented mainly with low or no risk factors, requiring no psychosocial supports. Some women presented with one to two risk factors requiring repeat EDS. A smaller proportion, but often complex group, presented with a combination of distress and high levels of psychosocial risk factors requiring case planning.

Similarly, Matthey et al. (2004) found in a predictive study of the psychosocial assessment and depression screening, that 40% of women presented with low risk status (1-2 risk factors) and 10% showed medium risk (3-4 risk factors). A recent review by Johnson et al. (2012) suggested that further testing is required of clinical tools used in assessment and screening. The results of Johnson et al. (2012) review of assessment tools demonstrated few normative data and inadequate sample sizes to
indicate that current assessment tools such as the EDS and the ANRQ can be recommended (Johnson et al.).

2:2:2 Adequacy of resources and care pathways

Historically maternity services have responded to the physical aspects of pregnancy and birth and the management of associated problems. Little attention has been paid to identifying or addressing the social and emotional needs of women and their families. If a need became apparent then a referral would be made to a psychiatric service. In the current recommendation of routine assessment and screening; all women are to be asked questions about mental health problems and social and emotional needs by maternity services; it is, however, resource intensive. If women are identified with potential risk factors they then require access to appropriate treatment and services (Buist et al., 2007). However, whether these women receive a referral may be dependent on availability of an appropriate service pathway (Hirst, 2005).

One key issue, identified in a number of countries, is the difficulty experienced in meeting the needs of all women who are identified with psychosocial distress and potential perinatal mood disorders. The reluctance to maintain screening programs stems from the fear of overburdening services (Buist et al. 2007). In a meta-analysis of screening for depression, Pignone et al. (2002) found that there were benefits to screening as long as pathways were clearly defined. Commonly reported system difficulties include the lack of referral pathways and training opportunities for staff to identify and manage maternal mental health issues (Rowan and Bick, 2008). Austin, et al. (2007) argue that psychosocial assessment should not be implemented until there are resources and clear referral guidelines to action interventions that support women with increased risk factors.
In Australia, there is evidence that not all women have equal access to publicly funded maternity and child health services. Reviews nationally (Brinkman et al., 2012), particularly in Victoria (Laurence, 2005) and in Queensland (Hirst, 2005) identify the inadequacy of maternity services in responding to the needs of vulnerable and disadvantaged families due to a lack of referral options, poor coordination of available services, and limited mechanisms to transition a woman’s care from one service to another. Such fragmented maternity care may result in women having to repeatedly explain sensitive details of their history which can be a traumatic experience for women and it is a resource intensive process (Laurence 2005). Similarly, a trial of sustained nurse home visiting in South-Western Sydney (Kemp et al., 2008), found that 40% of women did not receive a routine home visit in the first six weeks following birth. This is contrary to policy directives that all newborns and their families should be offered a home visit by a CFHN within two weeks of discharge from maternity services (Kemp et al.).

The integrated care principles in the NSW Safe Start guidelines are recommended to increase accessibility and assist in the seamless transition of women through health services including perinatal mental health (NSW Department of Health). However, as Myors et al. (2011) highlight there are government and organisational challenges to providing integrated care and encouraging collaboration amongst perinatal mental health service providers. Concerns exist that the process of the identification and responsibility for services, may lead to the segregation of service providers and the development of ‘issue silos’, or some aspects of perinatal care being considered more important than others (Smyth et al., 2006); this may leave some women marginalised and isolated. Myors et al. argue that for effective perinatal mental health care response, health professionals require skills and need to
work across disciplines; both before and after birth providing continual models of care.

2:2:3 Skills required by professionals

Most researchers agree that primary care clinicians such as midwives, CFHNs and general practitioners are well placed to conduct psychosocial assessments and depression screening as they are more likely to have an increased awareness of women with potential risk factors. However, there are differing perspectives on how best to implement this process (Mollart et al., 2009).

Factors that may hinder the assessment and screening process include the clinicians’ perceptions of psychosocial risk factors, personal values and their differing levels of communication and interpersonal skills. Marron and Maginis (2009), in focus groups with CFHNs in rural NSW, found that CFHNs may alter the assessment process or may favour their own clinical judgment in determining who requires assessment and screening. Concern here is this may result in potential risk factors being unexplored by CFHNs (Marron and Maginis).

Levels of comfort in asking questions can be influenced by the life experience of a midwife or CFHN (Ramsay et al., 2002). Negative or pessimistic view of aspects of the psychosocial assessment may inhibit a midwife’s or CFHN’s ability to conduct the assessment adequately and may result in fewer assessments (Moran et al., 2003). Some midwives and CFHNs may feel more confident in responding to specific risk factors if they have had prior personal experience of the issues in question (Chang et al., 2008).

The level of experience a midwife or CFHN has may alter their approach to assessment and screening. Ramsay et al. (2002) found that less experienced CFHNs used an approach that was more rigid and structured than those with more experience
who adopted a conversational approach. Factors that may influence a CFHN’s approach may be their knowledge and skills acquired through training, experience and exposure to the practice of others (Marron and Maginis, 2009). The SFE policy in NSW recommends and has supported education and training. At this stage in NSW, most CFHNs have been educated in Family Partnership Training (Davis et al., 2002) and midwives and CFHNs have been provided with Safe Start online training modules.

These current training opportunities focus on the importance of the developing relationship, effective listening skills, enhanced assessment and problem solving skills during psychosocial assessment and depression screening (Health, 2009). However, the number of clinicians who have received this training is unclear. Further studies are required to investigate the approach midwives and CFHNs take to make these sensitive enquiries and what additional supports are required to improve the CFHNs’ capacity and reduce barriers, such as addressing the timing of when and where assessment occur, to improve the practice of psychosocial assessment (Marron and Maginis, 2009).

2:2:4 The timing of and having the time for, psychosocial assessment

Midwives and CFHNs report that the timing of psychosocial assessment and depression screening places them in a precarious situation where they have to balance the inclusion of routine assessment and depression screening at the same time as they are attempting to establish trust with the woman. Potentially fragile and tenuous relationships rely on building trust in order for women to feel safe to disclose sensitive information (Kardamanidis et al., 2008). McCourt (2006), reports that midwives and CFHNs perceive a dissonance between the requirement to conduct
assessment and screening and investigate any potential risk to the woman while simultaneously developing a trusting relationship.

The process of assessment is time consuming and there is a risk that insufficient time may be given to meet the needs of women (Mollart et al., 2009). The suggested timing of the assessment is the antenatal booking visit and within the first 6 weeks post birth (Health, 2009). The antenatal booking visit is for many women their first engagement with services; it is a time when midwives and CFHNs are establishing relationships with the women. Although midwives and CFHNs may describe the timing of assessment as providing an early opportunity to identify the needs of a woman and provide any necessary interventions, the time allocated may not be sufficient to adequately explore all potential risk factors and allow the woman to discuss related issues. In some clinical areas nurse managers have increased the time allocated to CFHNs to conduct the assessment and screening in an attempt to alleviate this problem (Schmied et al., 2010).

2:3 Women’s experiences of psychosocial assessment

While there are questions about the specificity and sensitivity of the screening tools, such as the EDS and their capacity to predict depression (Austin and Lumley, 2003), it seems that it is generally agreed that the systematic nature of working through an assessment tool and asking questions around sensitive issues is, from a health professional perspective, beneficial for many women (Blackmore et al., 2006). However, the literature reports conflicting findings about women’s experiences.

In Australia, there have been a number of studies using telephone surveys to ask women about their experience of depression screening and, in some cases, about psychosocial assessments (Leigh and Milgrom, 2007, Buist et al., 2006b, Matthey,
These studies have found that most women report that the use of the EPDS did not cause them any distress and was highly acceptable. They reported it to be relatively easy to complete and it did not cause discomfort (Buist et al.). Women perceived being asked these questions as ‘caring’ on the part of the midwife and generally appreciated the opportunity to talk about their personal situations (Austin et al., 2013).

Contrary to these findings, in face to face interviews with women, UK studies (Shakespeare, 2003, Cowley and Houston, 2003) found that women were dissatisfied with the assessment and screening process. Some women felt judged, stigmatised, distressed and victimised by the questioning which resulted in instances of women denying problems such as domestic violence or their own negative childhood experiences (Cowley and Houston). Women also felt it was more appropriate for assessment and screening to be conducted in the home environment, rather than in the baby health clinics, to ensure privacy, adequate time and a more relaxed approach (Shakespeare).

Buist et al. (2006b) challenges the findings by Shakespeare et al. (2003) attributing the negative experiences reported by women, to the level of training of health professionals in conducting the assessment and screening process. However, Buist et al. also found that women may become distressed as a consequence of discovering they had scored high on the EDS/EPDS. As a consequence some women reported being fearful that there was something wrong with them when clinicians inquired further or suggested the need for supportive interventions (Buist et al.).
2:4 Midwives’ and CFHNs’ experiences of psychosocial assessment

There are few studies on the experiences of health professionals undertaking assessment and screening in the perinatal period. The key themes that emerge from the literature reviewed include the midwives’ and CFHNs’ concern that asking sensitive questions may impact on the relationship between the woman and midwife or nurse (Phillips et al., 2007), and that in such a structured approach women will not disclose personal experiences (Kardamanidis et al. 2009). Health professionals are also concerned about their skill and knowledge for conducting psychosocial assessment, their personal life experiences (Marron & Maginnis 2009) and the impact that assessment may have on the health professionals themselves (Mollart et al. 2009).

A recent Australian qualitative study by Schmied et al. (2008) found midwives had a positive experience when asking women questions included in the psychosocial assessment and depression screening process. These participants reported that the experience had enhanced their scope of practice, providing them with the opportunity to expand their role to incorporate a more holistic approach to care of the woman and her family. They noted that this resulted in their care becoming more women-centred and ‘not just about babies’ and not just focused on ‘nipple to knee’ (Schmied et al.).

On the contrary Mollart et al. (2009) in focus groups with midwives, found that prolonged exposure to traumatic stories may directly impact upon the emotional wellbeing of the midwives. Midwives described that the repeated exposure of women’s trauma led them to feel helpless and overwhelmed, frustrated and stressed. If the midwives lacked support they developed negative and pessimistic attitudes which impeded the development of therapeutic relationships and resulted in them
being unable to regenerate following an assessment. This is commonly termed ‘compassion fatigue’ (Mollart et al. 2009) and refers to the ‘profound emotional and physical erosion that takes place when clinicians are unable to refuel and regenerate’ (Mathieu, 1997). Mollart et al. highlighted the importance of providing supportive interventions for midwives who conduct psychosocial assessment and depression screening.

2:5 Relationships between women and health professionals

In interviews with women and CFHNs ((Kardamanidis et al., 2008, Phillips et al., 2007, Briggs, 2006) it becomes apparent that if health professionals exhibit a non-judgemental and supportive approach, trust is more likely to develop within the relationship and women are more likely to disclose sensitive information. The underlying reason for women not disclosing seems dependent on the level of trust within the therapeutic relationship (Kardamanidis et al.) as most women fear the involvement of child protection agencies if they disclose sensitive information (Phillips et al.). Clinicians experience over time, developing relationship and fostering encounters that encourage partnership and trust when working with women, increases clinicians possibilities of positive encounters in clinical practice. Through reflection, clinicians develop expertise and change the way they work in partnership to one that is more conducive to women feeling safe and able to discuss sensitive issues (Hopwood et al., 2013).

Midwives and CFHNs prefer to spend time with women developing and establishing therapeutic relationships and acknowledging that ‘…it may take a number of visits to establish trust and rapport’ (Phillips et al. 2007, p.368). Furthermore, CFHNs prefer to delay the assessment and screening process until after
the initial home visit to further establish the therapeutic relationship (Phillips et al.). (Moran et al., 2003) in studies into substance use assessment, argue that if greater time is spent with the woman on the first visit developing relationship, clinicians are more likely to identify potential risk factors. In some areas of known disadvantage the critical role of the relationship between women and health professionals assists to uncover potential risk factors (Kemp et al. 2007).

2.6 Other approaches to psychosocial assessment

In light of these concerns about how women may experience the assessment and screening process, other approaches have been investigated (Cowley and Houston, 2003). Cowley and Houston (2003) reject a structured format for assessment, believing that it does not allow for the flexibility required to elicit sensitive information and suggest that these issues should be uncovered by the health professional during their contact with a woman. This was echoed by Kardamanidis et al. (2008), in interviews with CFHNs they found that women were more likely to disclose sensitive information when time was taken to build a trusting relationship than if they are simply asked a series of prescribed questions.

In Victoria this concern led to the development of a new (ANEW) approach to assessment and screening that focuses on the capacity of health professionals to create a therapeutic environment more conducive to disclosure of sensitive information. This involves skills in asking key questions, in a sensitive way, related to potential risks or concerns clinicians may have for a woman, rather than relying on a structured tool to provide these prompts. This requires enhanced listening skills, emphasising the detection of important cues by clinicians during conversation and providing psychosocial support to those women in need (Hegarty et al., 2007). An
evaluation of the ANEW training program indicated that both midwives and general practitioners were more confident in their skills to elicit sensitive information in this manner (Hegarty et al.).

2.7 Organisational support and clinical supervision

To help facilitate the psychosocial assessment and depression screening process, Chew-Graham et al. (2009) describe clinical supervision as an important, but not the only support, required to enhance the CFHNs’ experience (Chew-Graham et al.). Organisational support is required to redesign and encourage environments that are conducive to the exploration of sensitive issues. Commitment from organisations to provide ongoing training, educational support and supervision of staff that are conducting assessment and screening (Chew-Graham et al.) are also important elements of the support needed.

Clinical supervision affords midwives and CFHNs an opportunity to critically reflect on the impact of conducting psychosocial assessment and depression screening with women. With supervision midwives and CFHNs are able to debrief about the orientation of particular cues during assessments whilst providing them with an opportunity to increase their capacity to respond to positive responses and provide supportive interventions for women (Marron and Maginis 2009). A clinical supervisor is well placed to highlight possible ‘blind spots’ of which the CFHN may not be aware (Bradshaw et al., 2007). Further studies are required to examine how regular clinical supervision can be provided and its impact on midwives and CFHNs conducting assessment and screening.
2:8 Summary

The literature presented here provides an overview of the current context and process of psychosocial assessment and depression screening and the challenges midwives and CFHNs face during psychosocial assessment and depression screening. It has also reported on the limited literature describing women’s experiences. There appears to be a lack of agreement on assessment tools, assessment approaches, the benefit or harm to women/health professionals conducting assessments and adequate referral pathways. It appears that if midwives and CFHNs were supported through training and clinical supervision, they may view the inclusion of psychosocial assessment and screening in a positive way (Schmied et al. 2008). Yet the psychological impact on individual health professionals can be significant (Mollart et al. 2009). Studies of women’s experiences of assessment and screening are limited but suggest that the process can be distressing for some women (Shakespeare et al. 2003).

To date no Australian study has examined the dynamics of the interaction between midwives/CFHNs and women during psychosocial assessment and depression screening through observation and engagement (interviews) with both participants (women and midwives/CFHNs). While the perspectives of midwives/CFHNs and women have been investigated largely with interviews, observations and reporting of the dynamics in the interactions between women and health professionals have not been examined. Furthermore, there does not appear to be any longitudinal studies that have observed women throughout their perinatal journey investigating differences in the interactions during assessment and screening at the two designated points in time, antenatally and postnatally; this is an important strength of this study. This study adds another dimension to existing
research by conceptualising and contributing to further understanding around
women’s experiences of assessment and screening and the nature of the emotionally
interactive work of midwives and CFHNs in the context of psychosocial assessment
and depression screening process.

Midwifery and nursing care is interactional and dynamic and the nature of
this ‘clinical’ work is often poorly understood and often unrecognised in practice.
Assessment of social emotional and mental health needs is multidimensional and
requires specific skills in understanding and interpreting women’s responses and
being able to attend to the emotional needs of women (Briggs 2006). The knowledge
gained from this study will provide clearer understandings of how the process of
assessment and screening is conducted and understood by its participants.
CHAPTER 3: Methodology

3:1 Overview of methodology

This chapter outlines the methodology and methods used in this study that sought to examine and understand the meanings midwives, CFHNs and women make of the process of psychosocial assessment and depression screening undertaken during pregnancy and early parenting. In this study I was particularly interested in examining in detail the dynamics of the interaction between the midwives and CFHNs and the women relating to: communication styles used and how this changes across both consultations, antenatally and postnatally; how midwives and CFHNs introduce the psychosocial assessment questions; the approach taken to incorporating these questions into interviews with the women and the women’s reactions and responses. The study is significant and innovative as it takes a new approach to research in this area. This is the first study to follow the same group of women through their perinatal journey from pregnancy to six to eight weeks after birth, investigating the dynamics of the assessment and screening process and using a combination of in-depth qualitative methods, observations and interviews, at two different points in time.

3:2 Ethnography

Ethnography, as a qualitative research method, was determined to be the most appropriate methodological approach to investigate the significance of the psychosocial assessment and depression screening in the perinatal period and to explore the meanings that women and health professionals (midwives and CFHNs) ascribed to this process. How individuals make meaning is largely dependent upon their socially constructed view of the world they enter or are immersed in (Crotty,
Ethnography allows the investigation of the meaning or sense that women make of their early encounters with maternity and child and family health services, particularly their experiences of the process of assessment of social, emotional and mental health. This study also explores the meaning midwives and CFHNs attribute to the sensitive questions asked and how this influences the way they deliver the questions and their responses to the women’s disclosures. For example, if a woman was offered some additional support or referral, how did she then interpret this offer of service and the type of intervention offered? The study of these clinical encounters assists in determining how the meaning made by an individual woman or health professional influences the dynamics of the interactions and how women and health professionals create a shared understanding.

As an ethnographic study, an interpretive approach is taken to inquire into the meanings behind what is observed, heard and understood from the perspectives of the women and the health professionals. During this process interpretations of day-to-day interactions cannot be separated from participants’ backgrounds, history, context and prior understandings. This study reports on the multiple perspectives of how participants communicate meaning, and identifies the factors that influence the development of meaning and the complexities that underpin the meaning. Other factors examined and known to influence interactions and shape meaning are described by Creswell and Clark (2007) as environmental and organisational contexts such as design and layout of environments, training and education.

Ethnography is described as a story in the past, present and future of a social setting, where the depiction of each part depends upon the researcher’s conception of the whole (Plummer, 2001). It is both a theoretical and philosophical framework (Brewer, 2000) and a process of collecting fieldwork data, organising and editing and
the presentation of a product, which, in this case, is a written thesis with publications (Atkinson et al., 2001, Bryman, 2004, Skeggs, 2001). This methodology developed from anthropological studies of culture (Crotty 1998). A culture is derived from a set of guidelines both explicit and implicit that tells individuals within a particular society how to view the world, how to experience it emotionally and how to behave when relating to others (Crotty). Individuals generally do this through the use of symbols, language, art and ritual (Hodgson, 2000). The aim of ethnography is not simply to find the answers to the questions that the ethnographer brings into the field, but also to find the responses to the questions that are observed during the fieldwork process. It is not the role of the ethnographer to predict behaviour, but to describe ‘rules of culturally appropriate’ behaviour (Frake, 2001).

Ethnography takes a constructionist view to understanding knowledge and experience (Schwandt, 2007). Constructionists reject the view of human knowledge that an objective truth exists separate from us and waiting to be discovered. Constructionists share the view that humans have the potential for meaning existing within and that meaning emerges when our conscious process engage with external objects; we construct meaning as we engage with the world (Crotty 1998). ‘Truth’ or meaning for constructionists is derived from the interplay between the object and subject and is not discovered but constructed by humans engaging with the realities in their world (Crotty). ‘Truth’ is created from our perspectives of our world, of the culture or the institution, that we immerse ourselves in and are immersed in.

From a constructionist viewpoint, humans construct meaning all the time in their own minds. This occurs during social interactions where we interpret meanings within or about interactions, based on our understandings and interpretation of the social world we exist in and how we perceive ourselves and others in our world. As
humans we create and use cultural symbols, signs, language, mores and values, to
direct behaviour and organise experience. We learn, interpret and understand, and
continue to reflect and reconstruct meaning throughout our lives based on
perceptions of experience (Creswell and Clark 2007).

In turn, as we construct meanings during social interactions and through the
interpretation of other’s symbols, language and signs, we express them through
dialogue and behaviour. Therefore, behaviour and dialogue depend on and are
largely influenced by, our interpretation of other’s actions. We present ourselves to
others based on the meanings we ascribe to their actions, yet we remain hidden from
the ‘truth’ or the reality of each other’s experiences. In this understanding of
meaning, it is possible that during interactions humans are constructing different
meanings in different ways - even in relation to the same phenomenon (Crotty 1998,
p. 176).

Ethnography is symbolic and interactional. It is an interaction between the
researcher and the people who make up the society being studied; it is symbolic as
the symbols of language are used to interpret the cultural practices of others (Crotty
interactional and social accomplishments. The aim of the ethnographer is not simply
to describe the social situation but to examine the perspectives of the observer and
the observed. Ethnographic work is the celebration of the richness and diversity of
human social life, but at the same time seeks to identify generic features. It is,
however, not a ‘truth’ but the researcher’s representation (Hammersley and
Atkinson, 2010). Observing people within their own setting is an attempt to perceive
their world and practices from an insider’s view. The role of the ethnographer
according to Brewer (2000) is to describe the relevance of the setting and topic,
identify features to be addressed in the study and those which remain uncovered, outline methods employed, explain problems that arose during fieldwork and provide positive, negative and comparative aspects of the data.

The ethnographer is described as both an insider and an outsider in the world being studied (Thomson, 2011). He or she is an insider, through becoming a participant in the social world being studied, but also an outsider, as the fieldwork must be interpreted and translated into text (Bryman, 2004). In this study I was an insider, as a mental health nurse I was already a part of the social world of nursing. However, I was not an intimate insider in that I wasn’t a midwife or CFHN. I had to balance my accepted ‘insider’ position as a nurse with my role as a researcher, ‘the outsider’. As the instrument of data collection in participant observation I had the ‘insider’, relationship to the participants inside the field of research, but also ‘outsider’ status, through the professional distance which permits adequate observation and data collection (Brewer 2000). I was also an outsider in that I was observing interactions, recording details about the participants, taking this information away and writing about the interactions and responses. This is not always favourable towards the insiders and I was mindful and conscious of how I interacted with the participants around the data I was collecting. For example, following an observation some participants turned to me asking me ‘How they went?’ I very diligently replied ‘How do you feel the visit went?’ My role as researcher and ethnographer is described by Frake (2001) as one seeking to discover and then describe, not prescribe the significant aspects of the participant’s world being observed.

Specifically the focus of this study is on the nature of the interactions that occur between midwives and women and CFHNS and women, in consultations about
their social, emotional and mental health in pregnancy and after birth. The study also involves consideration of the everyday context within which the interactions occur such as policy requirements. However, the study was not designed to look broadly at midwifery or nursing clinical practice issues but rather to focus on the context of psychosocial assessment and depression screening. Theoretical understandings of how humans construct meaning informs this study as the focus was social interactions during psychosocial assessment and depression screening and how both the woman and the health professionals make sense or create their own meaning.

This study investigated the meaning women and professionals assign to the questions in the assessment and screening and how this process impacts upon them.

3.3 Method

The methods of data collection chosen for this study were observations, face to face semi-structured interviews and focus groups. These methods have been used by other researchers (Fenwick et al., 2008, Dykes, 2006, Kruske et al., 2006, McCourt, 2006) in studies of midwifery and nursing care in the perinatal period. McCourt (2005) suggests that an observational approach is more suited to studies that investigate the communication styles and approaches to interactions between midwives and women at the first antenatal visit. Observation can reveal nuances and complexities that occur within interactions. Subtle communication issues are not easily identified and extrapolated in research methods that do not include observations (McCourt, 2005).

Data in this study was gathered through direct observations during psychosocial assessments in the antenatal clinic and at the Universal Health Home Visit (UHHV) as well as interviews with the women and focus groups with the midwives and CFHNs. An observation tool, 4D&4R, (Rollans, 2013a) was developed by the
researcher, in consultation with supervisors and the research team, to identify patterns in the interactions, provide consistency in recording observations but not limiting the use of free flowing field notes. The 4D&4R tool was used together with detailed field notes to collect data related to the interactions of the participants during the assessment and screening process. Further details are provided later in this chapter and in Chapter 4.

3.4 Study Settings

This study’s sites were located across two local health districts (LHD) in Sydney, NSW. The antenatal setting included the antenatal clinics of two tertiary referral metropolitan hospitals. The postnatal sites included Early Childhood Centres (ECC) where the CFHNs were based (further information about each of the sites is provided below). The postnatal sites were within the same LHD where the antenatal settings were located.

Site A, a local health district, has a population of approximately 820,000 people and is among one of the most rapidly growing populations in NSW. Only 60% of the population are English speaking and represent a large multicultural population, with approximately 40% of the population born outside of Australia. The largest cross cultural representation is from South East Asia (14%) and the Middle East and Africa (12%) (NSW Government, 2011).

Site B, also a local health district, with an estimated population of 795,000, with 70% of whom speak English with approximately 30% being born outside Australia. The majority of the cultural representation is from South East Asia (6%) and North East Asia (7%). Both sites provide publically funded maternity and postnatal care for two of the highest birth rates across NSW (NSW Government,
2011). Site A, local health district has approximately 12,000 births a year and site B, 11,000 (Li Z, 2011).

3:5 Study Sample
Participants in this study comprised pregnant women/mothers, midwives and CFHNs who undertake psychosocial assessment and depression screening.

3:5:1 Women
Pregnant women, having their first or a subsequent baby, were included in this study. Potential participants were informed about the study via information leaflets included in a package mailed to the women by the hospital prior to their first appointment (booking visit). Interested women were encouraged to make contact with me to discuss participation in the study, however, no women made contact in this way. To follow up the first invitation the researcher was available on a regular basis in the waiting area of the antenatal clinic to provide women with further information about the study and invite them to participate. Recruitment of women occurred in the antenatal clinic waiting area where I approached women and discussed the study with them. Women were provided with participant information sheet; consent forms and willing participants completed consent forms and returned to researcher (MR).

In addition to providing women with information whilst in the antenatal clinic, I also took note of the women who were allocated to consenting midwives on the list of bookings for the morning and afternoon booking visit sessions. I then approached these women to ask if they had received information about the study, provided them with further information and invited them to participate. Women who were allocated to one of the participating midwives were also approached by me 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. A total of 50 women were approached antenatally and 34 agreed to be observed during the booking visit with the midwife and at the first appointment with the CFHN services. They were also asked if they would agree to participate in a face-to-face or telephone interview two to four weeks following each observation.

On occasions women’s partners were present for some of the interaction. At site B partners were able to attend for some of the visit and at site A partners were told they were unable to attend the booking visit. At site B partners were asked to leave prior to asking the psychosocial assessment and depression screening questions, therefore, partners at both sites were excluded from the psychosocial aspect of the visit and, therefore, from this study. Due to the study’s focus on the process and impact of assessment on women and clinicians, partners were excluded from this aspect of assessment therefore consent was not obtained from women’s partners. However, where partners were observed during aspects of the interaction, the observations are only reported within the context of the women’s experience, i.e. when partners were asked to leave the visit, how did this make the woman feel? Or what were their perceptions of partners being asked to leave?

Exclusion criteria:

Women were excluded from the study if they spoke insufficient English to participate in a face-to-face interview without an interpreter. This was necessary as the study focused on the interactions between professionals and women and the interaction may be altered if an interpreter is present. These exclusion criteria, however, did not limit the participation of women from non English speaking backgrounds.
Thirty four women were recruited to the study. On average participants were 30 years of age, over half (20 out of 34) were born in a country other than Australia. Five of these 20 women were born in English speaking countries such as Ireland, United Kingdom; 15 women were born in non-English speaking countries such as Egypt, Laos, India and China. Eleven women spoke a language other than English. Eighteen of the 34 women were having their first baby, however, 10 of these women had previous pregnancies but had no living children due to miscarriages or terminations of the pregnancy. The participants were well educated with 30 of the women having tertiary qualifications and all participating women were either married or living with the partner, who was the father of the baby. In this study men who attended the booking visit or who were present at the postnatal visit were not expected to be part of the assessment process; consent, therefore, was not obtained from them to observe the assessment process. The data that is reported in the findings regarding the men in attendance is obtained through observation of the interaction of the midwife or nurse.

Initially all 34 women agreed to being observed at both time points, however in the postnatal period, only 20 of the 34 remained in the study. The other 14 women were not observed due to varying circumstances such as: relocating out of the area where ethics approval had not been obtained for observations (n=5); withdrawing from the study (n=4); challenges involving coordinating visits with CFHNS and the women (n=2); the woman did not attend the scheduled appointment at the clinic (n=2) or they refused a postnatal visit from the CFHN (n=1). However, 9 out of the 14 remaining women agreed to participate in follow-up interviews even though observations were not conducted.
A follow-up phone call was provided to 31 women at approximately 36 weeks gestation and once following postnatal observation to assist in retaining women in the study. No formal data was collected at this time; the contact was merely to facilitate ongoing relationships with participants to assist in retaining them in the study. The contact provided the women with an opportunity to briefly describe their experiences of the interaction, to confirm a follow-up meeting time with me to explore and record their experience.

3:5:2 Midwives and CFHNs

Midwives

Midwives received information about the study through in-service sessions conducted by me at each site; questions were answered and then interested midwives were asked to contact the researcher. I attended the antenatal clinic on days that the consenting midwives were working. Sixteen midwives and two student midwives, who undertook psychosocial assessment and depression screening as part of their role in conducting the antenatal history and health assessment in the antenatal clinics, participated in the antenatal component of the study. Six of the midwives were recruited from site A and 10 midwives from site B and one student midwife from each site. Midwives, other than the students, had an average of five years’ experience 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 postpartum).

Child and Family Health Nurses (CFHNs)

A total of 83 CFHNs participated in this study, 13 were observed during their interaction with the 20 postnatal women and 70 additional CFHNs participated in
discussion groups. Both the CFHNs and the women were recruited prior to the birth. Participant CFHNs were informed about and recruited to participate in the study through a series of in-service sessions conducted by me at each site. The women participants had been observed in the antenatal booking visit. After birth, women participating in this study were linked to a consenting CFHN, who was to conduct the home visit or the six week clinic visit, at which time the first author (MR) was present to observe the interaction.

All CFHNs working in these two sites were also invited to participate in a discussion group. Information about the discussion group was presented at the in-service sessions and consent was obtained at the start of the group. The professional experience of the participating CFHNs ranged from one year to over 20 years. The average age of the CFHN participants was 51 years, ranging from 28 to 62 years. Of the 13 CFHNs observed, eight had greater than five years experience as a CFHN. All the CFHNs were employed in universal services delivering a range of services to promote child health and development and to support families. Forty seven percent were fulltime employees and over half (51%) of the participating CFHNs were working part-time, with one CFHN working on a casual basis. All of these participants were registered CFHNs with specialist qualifications in Child and Family Health either as a post registration certificate, a post graduate certificate or a diploma. Although all 83 CFHNs had recently received family partnership training (Davis & Day 2010), only 40 % of the CFHNs reported that they had received training in psychosocial assessment and depression screening including the use of the EPDS and domestic violence screening. Mandatory online training was available; however few CFHNs had completed this at the time of data collection for this study.
3:6 Data collection

3:6:1 Observations

Data were collected via observation of the interactions between women and midwives/CFHNs at two points in time, once antenatally and once postnatally. Antenatal observations occurred with 15 women and seven midwives (including one student midwife) at site A and with 19 women and 11 midwives (including one student midwife) at site B. The length of time allocated to the midwife to conduct the antenatal visit varied between sites. At site A the allocated time was one hour and at site B, one and a half hours. The postnatal observations of interactions between CFHNs and 11 women at site A took place at the home visit conducted by the CFHNs 2 to 4 weeks after birth. At site B, nine women were observed in the health centre where the assessment was conducted by the CFHNs at 6 weeks after birth. The difference in time points of data collection was in response to differing implementations of the Safe Start policy (Health 2009) across the two participating sites and was unavoidable.

3:6:2 4D&4R an observation tool

An observation tool (4D&4R) was developed for the study (Rollans, M., Meade, T., Schmied, V. & Kemp, L. (2013a). Capturing clinician – client interaction: development of the 4D&4R observational tool. Nurse Researcher). The 4Ds component of the observation tool (introDuce, Deliver, Deal and Debrief) was designed to record details about the overall approach taken by midwives to psychosocial assessment and screening including how midwives introDuce the psychosocial questions and the 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 and CFHNs were 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 be highlighted by facial expressions indicating that the midwife was surprised, concerned, empathic or agitated.

The 4Rs component of the observation tool (React, Respond, Real experience and Reflect) was designed to guide the observer in recording the details of the woman’s responses to the questions, including aspects such as: How the woman reacted to being asked sensitive and intimate questions? Did she display any physical signs that indicated an emotional response to the questions (i.e. flushed face, smiling, frowning etc.); If she responded verbally, was she open and talkative in or did she withdraw from responding using monosyllabic responses or chose not to respond verbally at all. What was the real experience for her - How congruent did she appear for example, tearful at discussing traumatic events but denying distress. Was the woman observed to reflect on the questions being asked? Did she ask for clarification or did she raise her response to a previous question at some other point during the interaction.

A more detailed discussion of the observation tool is reported in Chapter 4 in the paper cited above and accepted for publication (Rollans, 2013a).

3:6:3 Field notes

Detailed field notes were used with the observational tool to document verbatim conversation between a woman and the midwife/CFHN during psychosocial assessment and screening. Notations were also made to elaborate on the verbal and non verbal communication observed. These interactions were not recorded due to the sensitive nature of the content of these discussions but I completed field notes.
including reflections on the interactions shortly after the observations were completed and drew on 4D&4R data as prompt for these notes.

3:6:4 Interviews

Midwives/CFHNs

Brief face-to-face interviews were conducted with the participating midwives and CFHNs directly following the observation session, either in the clinic or in the CFHNs motor vehicle following a home visit. These lasted approximately ten to fifteen minutes and sought to obtain the CFHNs impressions of the assessment and if they experienced any challenges or, alternatively, if they felt particularly positive about the style they used. These data were not recorded but were included in the field notes. The types of questions asked included: What did you think went well? Was there anything you might do differently? Were there any challenges or difficulties you experienced? And overall, how did you think the visit went? I also prompted the midwife or CFHN to discuss further any key observations they had made with regard to a particular style used during the assessment such as: How do you think you dealt with the woman when she began to cry? Was there anything in your practice that you believe made a difference to how she was feeling?

Women

Semi-structured interviews were conducted with 31 women in the antenatal period. These comprised 23 face-to-face interviews and 8 telephone interviews conducted within 3-4 weeks following the first observation at the booking visit. Interviews were conducted at the maternity unit when the women returned for their next appointments. The telephone interviews occurred 2 to 4 weeks after the observation at times convenient to the women. Following birth, 29 women agreed to an interview approximately 2-4 weeks after the first observation; 19 of these were conducted on
the phone and 10 were face-to-face and usually conducted in the woman’s home. These interviews comprised a series of open-ended questions to elicit information about the woman’s experience with the assessment process ((Rollans, 2013c); see Appendix D). The interviews took approximately 15-40 minutes and, with the participants’ permission, were digitally recorded. Interviews were transcribed verbatim with all identifying material removed.

3:6:5 Group discussions with midwives and CFHN

Focus groups were planned to be conducted in each setting with midwives and CFHNs but the sessions proved to be unexpectedly popular, particularly among CFHNs. As a result the groups were too large, 10 to 30 people, to be conducted as focus groups. Therefore, I refer to them in this thesis as discussion groups. Two discussion groups were facilitated with midwives and five with CFHNs who conduct psychosocial assessment and depression screening, for the purposes of identifying there: perceptions and experiences of undertaking psychosocial assessment; their beliefs about the nature of the relationship they develop with women/families; training and perceived skills required to undertake psychosocial assessment; their experiences of working in multidisciplinary teams and how these services influence outcomes for families. The key prompts are listed in (Rollans, 2013b) in Chapter 7. Each group had between 10 to 30 participants and lasted approximately one hour and, with the participants’ permission, were digitally recorded and transcribed verbatim with all identifying material removed.
The following Table 1 provides a summary of the recruitment process and the data collected.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Summary of number of participants and data collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives and CFHNs were recruited following researcher conducted in-services and education. Participant information sheets and consent forms were provided. Completed consent forms submitted to manager and researcher. Midwives and CFHNs were paired with a woman to be observed. Those midwives or CFHNs who agreed to participate in group discussions provided this consent at time of recruitment of observations.</td>
<td>Midwives = 16 midwives, 2 student midwives were recruited. Six midwives from site A, 10 midwives from site B and one student midwife from each site. CFHNs = 13 were recruited: seven CFHNs from site A and six CFHNs from site B.</td>
</tr>
<tr>
<td>Recruitment of women occurred in the antenatal clinic waiting area where I approached women and discussed the study with them. Women were provided with participant information sheet; consent forms and willing participants completed consent forms and returned to researcher (MR).</td>
<td>Women = 34 agreed to participate, all of whom agreed to participate in the antenatal clinic waiting area. 50 women were approached in the clinics by me. 15 women were recruited at site A and 19 women were recruited at site B. No women contacted me prior to attending their booking visit.</td>
</tr>
<tr>
<td>Observations of interactions between midwives, CFHNs and women</td>
<td>Antenatal = 34 women were observed during their booking visit. 15 women and seven midwives (including one student midwife) at site A and with 19 women and 11 midwives (including one student midwife) at site B.</td>
</tr>
<tr>
<td>Observations of interactions between midwives, CFHNs and women continued</td>
<td>Postnatal = 20 women were observed. 11 women at site A took place in the home visit conducted by the CFHN 2 to 4 weeks after birth. At site B, nine women were observed in the health centre where the assessment was conducted by the CFHN at 6 weeks after birth</td>
</tr>
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<tr>
<td>A phone call following antenatal observations was provided to foster relationships with the participants to assist in their retention in the study</td>
<td>Women who received the phone call = 31 women at approximately 36 weeks – no data was collected at this time</td>
</tr>
<tr>
<td>Face to face interviews occurred directly following interactions with all observed midwives and CFHNs. Phone call made with women to arrange time 1-2 weeks following the observation.</td>
<td>All 18 midwives and 13 CFHNs were interviewed. Interviews occurred antenatally with 31 women and with 19 interviews conducted postnatally with women. A further 10 women agreed to be interviewed about their experience of nursing services even though they were not able to be observed. Making a total of 29 postnatal interviews from women</td>
</tr>
<tr>
<td>Discussion groups - midwives and CFHNs who consented to participate in discussion groups were informed of the date and time when the groups were to be held. Additional midwives and CFHNs attended these groups.</td>
<td>Two discussion groups were conducted with midwives. An additional 70 CFHNs participated in five discussion groups.</td>
</tr>
</tbody>
</table>
3.8 Data Analysis

This study generated a large amount of data that were analysed descriptively using content and thematic analysis. Content analysis was applied to the data from the observational tool (4D&4R – Chapter 4, (Rollans, 2013a) which provided categories or domains for what was being observed during interactions (Krippendorff, 2004). Data from the tools were analysed descriptively using frequencies and proportions for aspects of the interactions such as physical gestures, such as smiling, or softly toned speech. Textual data from the field note observations, interviews and discussion group transcripts were analysed thematically (Braun, 2006). Applying a thematic approach to analysis includes exploration of sections of data, such as how observational field notes contribute to an emerging theme (Schwandt, 2007). The descriptive data obtained from the 4D&4R tool provided frequencies of the approaches taken by midwives and CFHNs to the assessment process and women’s responses. Frequency data illustrates common approaches and responses to assessment, these were then compared, contrasted and considered for consistency with the emerging themes.

3.8.1 Observation tool data analysis – 4D&4R (Chapter 5 – Rollans et al. 2012)

The observational tool data was used to identify the symbolic feedback and expressive behaviour (Lüdeling and Kytö, 2008) that each participant used during interactions - both verbal and non-verbal. Analysis of the subtle dynamics around the interaction, such as non-verbal behaviour, adds depth to the thematic analysis in understanding how clinicians overcome key concerns or challenges thematically identified during assessment through expressive behaviours (Pilnick, 2004). Head turns, smiles and phrases were consistently used. The field note data were referred to
in combination with these domains and frequencies to contextually describe the process of assessment and screening. Data included how a clinician greeted a woman, did they smile or introduce themselves and how many clinicians did this? At what points in time during the interaction did the clinician use particular phrases of their own to introduce topics or the assessment questions? These data were all recorded on the 4D&4R observation tool (Chapter 4 – Rollans, 2013a) and were used during the analysis to describe the content and the process or stages of the interaction.

I began the analysis of the 4D&4R tool data by recording the frequencies of each of the domains identified for observation (the 4Ds and 4Rs), in an excel spreadsheet where data could be calculated and incidences compared. This was then considered in the context of the field note data to provide greater depth and understanding of the key issues and themes that were emerging. Specific aspects, such as the use of eye contact and how participants used aspects of the environment, such as the computer, were used to analyse and create a story about each individual’s interaction. For example, in Chapter 6 (Rollans et al. 2013b) a theme was identified in the findings as ‘doing some paperwork’. This theme demonstrates a common phrase used by CFHNs to introduce the assessment questions and the EPDS. The frequency was calculated from the observation tool data with accompanying phrases derived from the 4D&4R observation tool data (Chapter 4 – Rollans, 2013a).

3.8.2 Field note, interview and discussion group data analysis

A key aspect of this study’s ethnographic approach to the interpretation and analysis of the data was to understand the process and the experience of the participants. Further critical inquiry was conducted during analysis about broader institutional and organisational issues that impact and shape the interaction and meaning. The political
context at the time plays a role in influencing the goals of improving health care and how this is achieved (Dykes 2006). At this stage of analysis the context of assessment and screening was considered, not just in regard to the social situation and the interactions occurring during the assessment, but also the responses or reactions that may derive from organisational or political issues. For example, structural issues in health, such as, negotiating policy implementation, whether clinicians felt they had adequate care pathways if needed, support education and training. Or how systems are organised within the health care setting to support or impede the assessment process. Also the context of professional relationships, which may be authoritarian and oppressive when individuals play out their role expectations and designations (Dykes); all may impact upon the interaction and the participants’ experience.

Thematic analysis involved multiple readings and re-readings of the data and listening to the recordings to become immersed in the data (Liamputtong, 2006). This was followed by identification and labelling of concepts in the data and development of preliminary themes from these concepts. This was an iterative process which involved all researchers discussing the concepts, themes and relationships during the preliminary analysis. I first identified themes and then consulted with the principal supervisor (VS) to further refine the themes after which review/consultation occurred with the co-supervisors (LK and TM). Emerging concepts and themes were constantly compared with other themes and refined (Liamputtong). This process resulted in identification of major themes for each of the data sets, antenatal, postnatal and the women’s data. 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?

3:9 Ethical Considerations

Ethical approval was sought from the Human Research Ethics Committees at both study sites and from the University of Western Sydney (UWS). Confidentiality was ensured and considered critical because participants were observed during interactions where they were revealing sensitive information about themselves and reflecting on the experience of making these disclosures with me during interviews and discussion groups. In this study, interview and discussion group data was in the form of digital recordings; therefore true anonymity was not possible; however, only I knew the identities of participants. Confidentiality was maintained through other measures, such as erasing digital recordings once accurate transcription of data had been verified. Other measures to maintain confidentiality include storing observational field notes and transcript data in a locked filing cabinet for a minimum of five years.

3:9:1 Consent

An important element of the right to self-determination is informed consent, which is understood as, participants having sufficient knowledge in relation to the research and consenting voluntarily to participate (Burns, 2009, Roberts, 2002). In this study participants were required to sign a written consent form (see Appendix G and H) prior to their participation. The consent form was written in everyday language that can be easily understood and comprehended by the lay person. Participants were made aware of the opportunity to ask questions and clarify points in the consent form.
and information sheet. Once participants read the information sheet (see Appendices B, L) and the consent form (see Appendices H, I, J), they signed the consent form and were subsequently recruited in the study.

Women participants were also reassured that their participation in the study would not interfere in their usual maternity or child and family nursing care. I reassured women that information about their experience remained confidential and that I would not share details with their midwife or CFHN.

3:9:2 Minimising the risk of harm

It was quite possible that participation in this study may have triggered some form of discomfort or harm, for example, asking women to reflect on their experience of being asked sensitive questions and disclosing negative life events. I attempted to do no harm and conducted the interviews in a sensitive manner. Participants were provided with time to consider their reflections and were not pressured for responses to my interview questions. I also accepted that some women may not want to discuss their experiences with me, reiterating to participants that they were participating voluntarily and could leave the study at any point in time. I was also prepared to provide participants with information about where they could obtain ongoing support should they feel the need to discuss any negative life events with professional counselling services. However, no participant required counselling due to distress during the interview.

The dissemination of findings from this study may present perceived risks to the organisations and health professionals. Health professional participants may also be concerned that their professional practice is under scrutiny and that what they say may be relayed to service managers and thus impact on their employment. Participants were informed that none of what is disclosed by individuals will be
reported back to managers or others in the health service and those specific sites will not be identifiable. Participation was completely voluntary.

3:9:3 Confidentiality and privacy

Confidentiality and privacy were adhered to. This involved withholding participant names and not revealing their identities. Participants’ names were present on consent forms and digital recordings. These documents along with the hard copy of transcripts were placed in a cabinet under lock and key for five years. Only I, as the researcher knew most of the identities of participants, however, in group discussions Virginia Schmied (VS) was present co-facilitating these sessions with me.

Pseudonyms were used throughout the interviews, the data analysis process, during the process of writing up the transcripts and when referring to participants in any other forms of documentation.

Due to the sensitivity of the data collected, as noted above, all women were provided with the opportunity to speak with the midwife/CFHN at the end of the observation without me present. Some of the interviews with the women following their assessment by the CFHN were conducted in the home environment if requested by the woman; this was the participant’s choice. However, information sought in the previous interviews antenatally informed of any potential risk. In regard to home visits with participants, I provided a contact mobile phone number and informed supervisors and managers of attendances in a woman’s home, expected time of meeting and its conclusion.
3:10 Chapter conclusion

The methodology for this study is ethnography; the philosophical, theoretical and methodological underpinnings of this research have been presented in this chapter. Data collection and data analysis approaches have been discussed and the ethical considerations have been identified. The following chapter presents publication one, the development of an observation tool 4D&4R (Rollans, 2013a).
CHAPTER 4:

The development of an observation tool: 4D&4R

4:1 Publication: relevance to thesis

The paper Rollans, M., Meade, T., Schmied, V. & Kemp, L. (2013a). Capturing clinician – client interaction: development of the 4D&4R observational tool. (Nurse Researcher) provides the background to the development of the observation tool 4D&4R). This paper focuses on identifying the components of 4D&4R for data collection by a single research observer; the components assist in guiding the collection of observational data. This published paper is an adjunct to the research methods and approach to the study described in Chapter 3.
Capturing clinician-client interaction: development of the 4D&4R observational tool


Date of submission: December 1 2011. Date of acceptance: June 18 2012.

Implications for practice

Aim To report on the development of an observation tool that can help a single researcher to collect field data about clinician and client interactions.

Background Qualitative studies from a range of disciplines investigate the dynamics of interactions between clinicians and clients. These studies share and report findings but rarely provide details on the practical challenges and methods involved in managing such interactions when collecting rich ethnographic data.

Review methods Development of the observational tool was informed by the study’s requirements and context, previous research, and the authors’ cross-disciplinary knowledge and experience.

Discussion In relation to how clinicians interact with clients and how clients respond, four domains have been identified and integrated into the observational tool. These domains act as prompts during observations of interactions between clients and nurses. Use of the tool has indicated its effectiveness in assisting with observations and the recording of field notes.

Conclusion The article shows how to develop a tool for qualitative field-data collection. The method can be adapted to studies that require observations of interactions and its components can be modified to suit their fields of study.

Implications for practice or research The 4D&4R tool discussed in this article provides indicators of clinician-client interactions and is transferrable to other research and practice contexts.

Keywords observation, field, notes, researcher

RESEARCHERS WHO observe clinical encounters in which sensitive information is given or sought can explore the multi-layered, subtle and complex dynamics of interactions in ways that interviewers and survey techniques cannot (McCourt 2006).

Given the necessity to observe attentively but unobtrusively, such research can be challenging. While audiovisual tools can help with data collection (Cowley and Houston 2003, McCourt 2006, Chang et al 2008), they may be perceived to be intrusive and their presence may affect the interactions being observed (Holloway 2005), particularly when sensitive and private information is being revealed.

How, then, can a single participant-observer without audiovisual recording aids record the complexities of interactions effectively? A number of researchers, such as Cowley and Houston (2003), McCourt (2006), and Chang et al (2008), have observed interactions between midwives, nurses and clients, and have identified aspects of these interactions, such as establishing rapport, responding to clients’ disclosures and providing support, that aid communication.

These communication strategies are described in theories of communication, such as the phase model (Edberg et al 1995) and feedback systems (Kettunen et al 2002), and are reported in integrated reviews of nurse-client interactions by, for example,

While some studies of nurse-client interactions concern tools devised and used to analyse recorded observational data (Latter et al 2000, Tejero 2010), few concern observation tools or techniques for real-time recording of field notes (Caris-Verhallen et al 2004) and so the authors of this article did not consider them useful for their study.

The authors therefore engaged in a three-stage process to develop an observational tool, entitled the 4D&4R, to complement and aid the recording of rich field notes. Their aim was to provide individual researchers with observational cues to assist in gathering consistent data and, although it has been designed for the observation of communication during interactions in maternity and community health settings, the tool is generalisable to other settings (Table 1). The tool’s structure is congruent with communication process models, such as Edberg’s phase model (Fleischer et al 2009), and it can be combined with other methods to gather rich ethnographic data.

Background
In the Australian state of New South Wales (NSW), the social and emotional health and wellbeing of all women is routinely assessed in the perinatal period (NSW Health Department 2009). Such assessments are sensitive, and little is known about how midwives and nurses conduct them or how women respond to them. The assessments involve asking women questions so that information about their psychosocial histories can be collected (Henshaw and Elliott 2005). The women involved may disclose sensitive information about their emotional and social wellbeing for the first time during these assessments (Chew-Graham et al 2008), which are conducted when service expectations and relationships are being established with maternity staff (McCourt 2006).

It can be difficult to collect observational data during these assessments because the use of video and audio recorders may be inappropriate. To record the subtle mechanisms of interaction, therefore, advanced observational instruments are needed (Caris-Verhallen et al 2004). However, while such tools can be developed for individual studies, they are rarely described in detail in the literature.

Most recent studies that describe how interactions between clients and professionals in maternity and community health settings primarily used audio-recordings of communication between clinicians and women (Cowley and Houston 2003, McCourt 2006, Chang et al 2008), although McCourt (2006) describes how observers in her study made brief notes and illustrations to explain participants’ use of space. These notes and illustrations were then analysed and inform parts of the audio transcripts.

Some of the earliest nursing field studies investigate the behaviours of nurses during interactions with patients. Hunt (1991), for example, recorded friendly and informal conversations between nurses and patients, and how patients’ relatives became involved in them, while Bottorff and Morse (1994) adopted an ethnological approach to the study of nurses’ and patients’ verbal and non-verbal communications, including touch. In these studies, Bottorff and Morse (1994) made video recordings of the interactions and used observation tools in the analysis of recorded data.

These first few field studies of nurses’ interactions have paved the way for further enquiries into clinician-client relations, and have assisted in the development of theories of the dynamic nature of the nurse-client relationship.

One of the first systematic reviews of nurse-client interactions was undertaken by Jarrett and Payne (1995). They report that earlier, non-systematic studies of nurse-client interactions focus mainly on task-orientated aspects of communication, for example during care provision or administration, and identify a need for nurses to develop good interviewing skills. There had been few studies of, for example, how nurses interact with clients to solve problems and plan appropriate care, or of how clients contribute to such interactions (Jarrett and Payne 1995).

According to Hewison (1995), the social context of unequal power in nurse-client relationships appears to affect clients’ ability to participate in decision-making processes and denies them a sense of autonomy. Meanwhile, the development of reciprocity in nurse-client interactions is examined by Shattell (2004).

Investigations of nurse-client interactions involves consideration of how data are gathered and analysed. For example, Latter et al (2000) have developed and validated a tool to be used in the analysis of audio-recordings of nurse-patient interactions during the administration of medication. This tool has been designed to capture the components and subcomponents of clinical judgements of nurses who are competent at medication administration. However, few studies that have used non-technological methods to collect qualitative data provide details of their data-recording processes.
Table 1 The 4D&4R observation tool

<table>
<thead>
<tr>
<th>Demographics: clinician, such as midwife or child and family health nurses</th>
<th>Professional experience (years)</th>
<th>Period working</th>
<th>Start point: midwife or child and family health nurses</th>
<th>Time commenced</th>
<th>Time completed</th>
<th>Setting</th>
<th>Client's wait time</th>
<th>Client's code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapport</td>
<td>Mood</td>
<td>Engagement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cold</td>
<td>Neutral</td>
<td>Warm</td>
<td>Negative</td>
<td>Neutral</td>
<td>Positive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1</td>
<td>Intro Duce</td>
<td>Not introduced</td>
<td>Introduced</td>
<td>Rationale explained</td>
<td>Privacy Act introduced and explained</td>
<td>Responds to woman’s questions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2</td>
<td>Deliver</td>
<td>Did not ask</td>
<td>Order: blended or structured</td>
<td>Wording: varied or structured</td>
<td>Eye contact</td>
<td>Tonality: loud, neutral or soft</td>
<td>Use of jargon</td>
<td></td>
</tr>
<tr>
<td>D3</td>
<td>Deal</td>
<td>Clinician does not respond</td>
<td>Clinician explores answers</td>
<td>Interventions: directed or collaborative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D4</td>
<td>Debrief</td>
<td>No debriefing offered</td>
<td>Encouragement or counselling offered, or client asked if she is okay</td>
<td>Timing of sensitive questions, affirmative answers and end points</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start point: client</td>
<td>Rapport</td>
<td>Mood</td>
<td></td>
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</tr>
<tr>
<td>Cold</td>
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<td>Negative</td>
<td>Neutral</td>
<td>Positive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R1</td>
<td>React</td>
<td>Posture, movements and gestures</td>
<td>Facial expressions: smiling or frowning</td>
<td>Voice pitch and tone, and intensity and fluency of speech</td>
<td>Autonomic: breathing changes, blushing and tremor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R2</td>
<td>Respond</td>
<td>Open and talkative</td>
<td>Withdrawn and unresponsive</td>
<td>Provides tangential answers</td>
<td>Appears preoccupied</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R3</td>
<td>Real experiences</td>
<td>Congruent or incongruent appearance or speech</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R4</td>
<td>Reflect</td>
<td>Debriefing carried out: specify timing of sensitive questions</td>
<td></td>
<td></td>
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Reproduction of this tool is permitted only if authorship is acknowledged on copies.
Studies involving the use of tools for observing the social and emotional components of nurse-client interactions often describe such tools as mechanisms to assist in the recording of structured data collected during focused observations. Tejero (2010), for example, developed and validated a tool to measure nurse-client bonding. Specifically, it was used to measure contributions by nurses and clients, as well as their openness to, and engagement with, each other.

It was also used to orientate the qualitative thematic analysis of the researchers’ data. However, because the tool was developed for a specific outcome, namely measuring bonding, the authors of this article found it unsuitable for their study, which sought to capture the dynamics of interactions between nurses and clients during structured clinical interviews.

The tool was developed, therefore, to:
- Identify the dynamic patterns of clinician-client interactions during clinical assessments.
- Assist in the recording of consistent data without interfering with free-flowing field notes.
- Ensure that observations focus on clients and clinicians equally.
- Complement ethnographic data collection.

Nutley et al (2007) report that, when developing strategies or systems for data collection, it is essential to state how the information will be recorded. It is also important that, in choosing categories or domains for consideration in data collection, researchers do not have preconceptions about the dynamics of nurse-client interactions (Sandelowski 2000).

Method and findings

The authors intended that tool should be user friendly, unobtrusive and manageable for individual, real-time observers. In developing the tool, the authors were guided in three ways. They:
- Took into account the aims and requirements of their study, the skills and experiences required by researchers to record field notes, and the data-collection methods to be adopted.
- Undertook review of the literature to determine the techniques and methods used in recording field notes in observational studies, particularly in interactions between nurses and clients in the period including pregnancy and up to six weeks after birth.
- Drew on their knowledge of methodological approaches to observational studies, and their collective professional experience in mental health, psychology, midwifery and nursing practice.

Aims and requirements

The tool is intended to be used in the observation of clinician-client interactions, particularly those in which clinicians are required to identify social and personal risk factors for poor health outcomes, such as lack of social support, previous mental health problems, childhood abuse and domestic violence, in the women with whom they interact (Buist et al 2007, Karatas et al 2009). By facilitating effective interpersonal relationships, clinicians can encourage the disclosure of sensitive information (Liebschutz et al 2008) by clients who are otherwise too fearful, uncomfortable or embarrassed to do so (Porter 1990, Phillips et al 2007, Chew-Graham et al 2008, Liebschutz et al 2008).

The researcher in the authors’ study required considerable skill in observing complex interactions in which sensitive information is disclosed. Ethnography was selected as the methodological approach because it involves people constructing meaning during social interactions based on their understandings of themselves, the social world and others in it (Crotty 1998, Creswell and Plano Clark 2007). The ethnographic data required for the study derives from the negotiation of meaning and responses during interactions between client and nurse.

Interactions between nurses and clients are usually the first in which large amounts of detailed information, often of a personal nature, are sought from the clients. Clinicians should be skilled in creating effective interpersonal relationships in which they can share in the experiences and concerns of the clients (Caris-Verhallen et al 2004).

Clinicians working with women in early pregnancy are often setting the scene for ongoing interactions with the clients and their families. The nature and style of these first interactions are crucial, therefore, because the women’s experiences of these encounters may affect their expectations of the health care they will receive (McCourt 2006).

Identifying how clinicians establish environments that encourage clients to disclose sensitive information, and reflect on and respond to the questions asked, are practical processes (Chew-Graham et al 2008). Factors that can affect this process include:
- How the environment is set up.
- The timing of the questions.
- The positioning of the participants in the interview.
- How the interviewee reflects on, and responds to questions asked (Porter 1990).

Because such questions are usually direct and closed (Lomax and Robinson 1996), the authors wanted
to observe the preparation clients receive before being asked the questions and how the questions are delivered.

Approaches adopted to describe these complex interactions vary across studies (McCourt 2006, Chew-Graham et al 2008). To explore how midwives, and child and family health nurses (CFHNs), communicate with perinatal women, the authors drew on theories that explain the dynamics of interactions. Fleischer et al (2009), for example, emphasise the importance of observing the structure of communication through application of the phase model (Edberg et al 1995), which involves ‘initiating’, ‘working’ and ‘terminating’ phases. Given the structured nature of the psychosocial assessment interview in nurse-client interactions, this model provided a good theoretical background for the development of the tool.

Communication is, by its nature, dynamic. Fleischer et al (2009) note that clients’ responses can be conveyed through non-verbal behaviours or verbal responses that include questioning the nurse, disclosing previous knowledge and interrupting various aspects of interactions (Kettunen et al 2002). These responses may collectively indicate clients’ experiences and reflections (Kettunen et al 2002).

**Literature** Most ethnographic researchers gather wide arrays of rich data, often through observations and detailed field notes. These are valued but challenging processes in ethnographic studies (Polit and Tatano Beck 2008). The writing of field notes requires careful consideration because it constitutes a central research activity in many observational studies (Hammersley and Atkinson 2007). However, large amounts of data become cumbersome to manage (Bryman 2004) and individual researchers may be unable to capture every detail (Holloway 2005), so they often make trade-offs, selecting aspects of observations to focus and record (Hammersley and Atkinson 2007). Individual researchers can develop, sometimes in ad hoc ways, categories that aid in recording reliable data and help with analyses (Parahoo 2006).

While extensive qualitative notes are common among researchers, these may be reduced to ‘thick’ recordings that are sometimes illegible (Holloway 2005). As Pope (2005) reflected on her ethnographic data collection, ‘my jottings, which run to many notebooks, are embarrassingly scruffy, consisting of fairly untidy writing’. As Hammersley and Atkinson (2007) note: ‘A research project can be well organised but with inadequate note-taking the exercise could be like using an expensive camera with poor quality film. Only foggy pictures result.’

While researchers may assume ‘seeing is believing’, their real challenge lies in identifying what they see (Holloway 2005). Ethnographers are rarely able to absorb all details of interactions and events occurring in their chosen fields without specifying what they are focusing on or identifying tools to record the details of events (Bryman 2004). As researchers maximise their accounts of their fields, they must record regularities and conventions, and exceptions and variations, equally. These descriptions provide reference points for individual researchers to interpret and explore during analyses (Holloway 2005), should allow for flexible and unstructured notes to be made, and can further explain and explore meanings attributed to the actions described (Hammersley and Atkinson 2007).

In observing events or people closely, researchers often become engrossed in specific and subtle dynamics inherent in their subjects (Kellehear 1993). Over time, individual researchers may need to record the details of their observations and, as they become more familiar with the environments, they may be tempted to minimise note-recording and focus on observing (Bryman 2004). The identification of categories or domains may help to organise observational material, and maintain consistency across observations and the richness of the ethnographic field (Holloway 2005).

**Knowledge and professional experience** The authors drew on their clinical experiences and insights into dynamic interpersonal relationships in psychology, psychiatric interviewing techniques in mental health, sensitive interviewing in midwifery, and the skills required by clinicians.

Components to be taken into account included how clinicians introduce interviews (Shea 1998), how clinicians respond to questions and whether they spontaneously explore issues that have been disclosed (Stein-Parbury 2009), and the value of debriefing clients after they have disclosed traumatic experiences (Rose et al 2009). Clinicians must also decide whether to adopt a ‘blended’ approach to question delivery, in which questions are incorporated into conversations, or a ‘structured’ approach, in which questions present series of questions are followed (McCourt 2006). The choice of domains to be observed was informed by decisions made about these components, and by the authors’ clinician knowledge and experience.

The research team discussed the stance individual researchers should take when recording field notes and agreed that the tool would be a guiding, but not determining, framework for observations; that is, researchers should remain open and not assume that
all characteristics of their observations would occur in the tool’s domains.

The tool forms one page of a clipboard that opens out as a booklet, with the other page being blank so that individual researchers can add their notes, ideas or explanations could be added.

Based on the study requirements, literature findings, the requirements of collecting qualitative data, and the authors’ understanding and vocational experience, they gave the tool two groups of four domains. Those in one group concern four different approaches adopted by clinicians:

- IntroDuce, or D1.
- Deliver, or D2.
- Deal, or D3.
- Debrief, or D4.

Domains in the other group concern four different responses by clients:

- React, or R1.
- Respond, or R2.

### Table 2 Description and illustration of the four Ds

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Relevance</th>
<th>Illustration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D1 IntroDuce</strong></td>
<td>Introducing, or familiarising the client with, the interview process so that she knows what to expect (Shea 1998). This can reduce fears or uncertainty among clients, who may feel discomfort or distress in being asked sensitive questions (Cowley and Houston 2003).</td>
<td>Researchers observe actions that ease clients’ discomfort at the start of interviews and note whether clinicians introduce questions, explain their rationale, discuss the Health Records Information Privacy Act 2002, explain what is done with information received and responds to clients’ questions.</td>
</tr>
<tr>
<td><strong>D2 Deliver</strong></td>
<td>How clinicians ask questions is an important component of health assessment. A structured approach is directed largely by a template or database, while a blended approach is more fluid and questions tend to vary so that clinicians can respond to clients’ cues (McCourt 2006). Interpretation of questions is influenced by non-verbal forms of communication (Egan 2010).</td>
<td>Researchers observe the delivery of questions to establish whether clinicians have taken a blended or structured approach. Researchers record the order and wording of questions, particularly when these vary from those in a structured approach. Researchers also record information related to non-verbal communication, including clinicians’ eye contact with clients, their tone of voice and whether they use jargon.</td>
</tr>
<tr>
<td><strong>D3 Deal</strong></td>
<td>Clinicians require skills to respond to positive answers during assessment and to notice when clients express their needs indirectly or directly (Egan 2010). Clinicians must be able to explore issues that are raised spontaneously (Stein-Parbury 2009).</td>
<td>Researchers observe how clinicians respond to disclosures and affirmative responses to questions involving psychosocial risk, and whether such risk is explored. Researchers also record whether and how interventions are provided. If interventions are directed, clients may be told what to expect; if they are collaborative, clients may have some choice over what happens next.</td>
</tr>
<tr>
<td><strong>D4 Debrief</strong></td>
<td>Sensitive questions are asked during psychosocial assessments and clients may be asked to recall distressing events. Debriefing involves supporting clients to reflect on any points during interviews when they found recalling traumatic events difficult (Rose et al 2009)</td>
<td>During debriefing, clinicians may simply ask a client ‘are you okay?’. Or they may encourage clients to discuss distressing thoughts or experiences, or offer them counselling. Researchers observe when sensitive questions were asked, how clinicians responded to affirmative answers and how the interviews ended.</td>
</tr>
</tbody>
</table>
Observation

Table 3  Description and illustration of the four Rs

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Relevance</th>
<th>Illustration</th>
</tr>
</thead>
</table>
| R1  React | Observations of clients’ non-verbal responses during interactions are needed if their experiences are to be fully understood (Egan 2010). | Researchers observe clients’ physical reactions, including their posture, movements or gestures, facial expressions, voice intensity, fluency of English and autonomic responses, such as a tremor and blushing. | Items to observe:  
- Posture, movements, gestures.  
- Facial expressions: smile, frowns.  
- Voice: pitch, tone, intensity, word spacing, silences, fluency.  
- Involuntary responses: blush, tremor.  
Example: the client sits forward in her chair, leans toward midwife and is softly spoken. |
| R2  Respond | How clients respond to questions indicates their willingness or reluctance to discuss the issues raised further (Tejero 2010). | Researchers record whether clients appear open and relaxed, or uncomfortable about the issues being raised or disclosed. Clients who become disengaged from conversations or less responsiveness to questions may express tangential thoughts. | Items to observe:  
- Openness and talkativeness.  
- Withdrawn and unresponsive manner.  
- Tangential answers.  
- Preoccupation.  
Example: the client answered all the questions asked. |
| R3  Real experience | Real experience refers to congruence or incongruence in messages conveyed, how the messages are conveyed verbally and non-verbally, and whether there is congruency between appearance and words. Incongruence could indicate that a client feels vulnerable (Grafanaki and McLeod 2002). | Researchers record clients’ level of congruency and how clinicians respond. | Items to observe:  
- Congruence or incongruence.  
Example: the client’s responses appear to be congruent with her appearance. |
| R4  Reflect | During debriefing, clinicians provide feedback to clients and ensure they understand each other. Clinicians may offer opportunities for debriefing when sensitive questions are asked or at the end points of interviews. | Researchers observe whether clients reflect on aspects of interviews, seek clarification or ask for more information. | Items to observe:  
- Debriefing and response to sensitive questions.  
Example: the client did not reflect on the interview. |

Real experience, or R3.  
Reflect, or R4.

From these two groups of domains, the tool derives its name, 4D&4R. Components of the 4D&4R observation tool are described in Table 2 and 3.

The tool was developed to include additional information, such as the rapport and engagement of clinicians and clients, along with their moods and how they were observed by each researcher at the start and end of each interview. Rapport is an essential component, whether for assessment or therapeutic purposes, in effective interaction, (Barker 2004). These aspects were included to add another level of detail and explanation to the observational cues.

Modifications to the 4D&4R tool’s components and terminology were made following its use in ten observations by the principle author, who has a background in mental health nursing.

For example, D3 initially related only to whether psychosocial issues had been identified and how the clinician had dealt with the relevant responses. It was changed to include information about whether these issues were identified by the clinician or principle author.

In addition, the difference between the terms ‘engagement’ and ‘rapport’ was clarified, such that ‘engagement’ describes a clinician’s efforts to communicate with a client and ‘rapport’ refers to the client’s response to such efforts.
Discussion
In developing and using 4D&4R, the principle author found that it was helpful in consistently identifying patterns without limiting broader observations outside 4D&4R components. For example, some of her observations refer to factors, such as privacy in the room where interviews were held, the presence of clients’ family members, clients’ specific expressions and language, and cultural differences between clients and clinicians, that appeared to influence shifts within the interactions (McCourt 2006, Chang et al 2008).

Overall, 4D&4R’s components were easy to use and provided the principle author with a systematic approach to observation and collection of data. The components of 4D&4R provide deductive themes, while the free-flowing field notes provide inductive themes that can assist in the qualitative analyses of collected data.

The tool allows individual researchers to identify patterns in interactions and commonalities in clinicians’ interpersonal styles, and helps them to understand the effects of sensitive questions on clients, commonalities across clients’ reactions and responses to the questions asked of them. The 4D&4R tool provides indicators of clinician-client interactions, particularly the reciprocity of the dynamics of such interactions.

Conclusion
Conducting research into the nature of clinician-client dynamics is complex and must remain sensitive to the field in which personal information is shared. To observe and identify clinicians’ approaches to psychosocial assessments, and their clients’ responses, the authors developed and tested the 4D&4R observation tool.

References


This development required consideration of the relevant theoretical and empirical literature, the requirements of qualitative data collection, and the researchers’ understanding and vocational experience in nursing, midwifery, psychology and research.

Development of the four components of the tool was informed by the authors’ understanding of communication and nurse-client interaction dynamics (Edberg et al 1995, Kettunen et al 2002). These components reflect a sequence of clinician’s approaches and clients’ responses to assessments, and include specific verbal and non-verbal cues (Figure 1). Also included in 4D&4R is a rating scale for measuring clinician-client rapport (Barker 2004).

The 4D&4R tool helped the principle author look for observational cues during nurse-client interactions, and provided alerts to specific dynamics in these interactions. As such, it may alert individual researchers to the complexity of the interactions taking place and help them to write field notes. It may also promote confidence and competence in the field among novice researchers.

The aim of 4D&4R is to guide and organise individual researchers’ approach to observations and recording of field notes.

It was found to be an efficient and useful aid in collecting ethnographic data. Although it was developed for a specific context, namely perinatal psychosocial assessment, it can be used to record clinician-client interactions and may therefore be adapted to other contexts with similar observational aims. Meanwhile, researchers can draw on its development process when creating similar aids for collecting qualitative data.

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**References**


4:2 Chapter conclusion

In this chapter I present publication one ‘Capturing clinician – client interaction: development of the 4D&4R observational tool’, which provides a detailed account of the development of the 4D&4R observation tool used to collect real time observations of interactions between midwives, CFHNs and women. The tool’s development was largely influenced by what was known about recording information during these types of interactions from the literature and from the knowledge and experience of the research team. The tool was designed to capture the approach taken by the midwives and CFHNs and the responses of the women, both verbal and non-verbal. The following chapter presents the environmental context, with regard to design and layout of the facility in which the antenatal and postnatal observations took place. My reflections on entering and being in the field are also included in the following chapter.
CHAPTER 5: ‘Entering and being in the field’

5.1 Design and layout of study settings

The ethnographic approach to research emphasises fieldwork which involves prolonged time spent in the field/environment by the researcher (Creswell and Clark, 2007). Descriptions of the environment are considered important in the context of ethnography; observations of the field where data is collected and the researcher’s experiences provide descriptive data and assist in analysis (Schwandt, 2007). The environmental context, with regard to the design and layout of the setting where the antenatal and postnatal observations took place and its possible impact on the clinicians or women’s experiences, together with my reflections or reflexivity, are presented in this chapter.

5:1:1 Antenatal clinic setting

At site A the clinic rooms where observations were carried out and where the midwife conducted the booking visit, opened directly to a busy and narrow corridor that acted as a thoroughfare to the tea room, other clinic rooms, the waiting areas and the exit. In addition to being a waiting area, there were workstations outside the clinic rooms where staff congregated to talk about clinical and other issues. In contrast at site B, clinic rooms were discreetly placed behind the administrative area precluding any intrusions either from staff or other activities in the waiting areas.

At site A the rooms were sparse comprising a desk with a computer and two or three hard plastic chairs all combining to give a sense of a cold, clinical environment. In some of the rooms there were posters on the walls illustrating health promotion messages, for example, posters highlighting the dangers of smoking during pregnancy. In contrast at site B, the midwives had personalised the clinic room putting up pictures of their own families or of women and babies they had
assisted in birth. Midwives at site A were dressed in hospital uniforms. In contrast, midwives at site B did not wear a uniform but instead wore smart casual clothes, in varying colours with accessories and jewellery.

5:1:2 Early Childhood Centre and home environment
The two postnatal environments where observations were conducted were, at site A the woman’s home, and site B, in community clinic settings. Whilst the home environments were influenced by the woman’s socio-economic circumstances, most were suburban brick houses with a backyard; a few women resided in apartments in building complexes. The community clinic rooms at site B were discreetly positioned away from waiting rooms where very little interference by noise or traffic was experienced. Consisting of three soft plastic cushioned chairs, a desk and an examination table usually covered in a sheet and with child friendly mobiles displayed above the table for the baby to look at.

5:1:3 Organisation of the clinical environments where assessment is conducted
The organisation and design of clinical environments is an important part of the description of the study’s settings as it influences how clinicians undertake their work. In this study the organisation of the environment also presented some of the challenges that are discussed in the findings Chapters 6, 7 and 8. Midwives at site B were observed utilising the time it took to walk from the waiting room to their clinic room to start to engage with the woman and her partner; ‘How you doing today?, Is everyone coming in for the session today? Hope you didn’t have to wait long? (SM2). Women appeared to respond positively to this engagement with their midwife, smiling and laughing along with the midwife during these interactions.

Both antenatal clinic sites appeared busy as there were women attending the clinics for subsequent appointments with midwives and doctors’ visits. In addition to
completing antenatal histories with women, midwives at both sites were observed helping with administrative tasks such as answering phones at the reception area or client queries at the reception desk. I observed that the midwives appeared willing to participate in these other duties which assisted in the smooth running of the antenatal clinics. The midwives perceived that other antenatal clinics had more resources allocated to booking visits and/or fewer women booked for visits.

I noticed that the noise level was high in the clinic areas and, at times, this appeared to impact on the interaction between the midwife and a woman. At one point in an assessment at site A, a midwife stated her difficulty to the woman and sought ways to overcome the distraction of the noisy environment:

_I’m sorry I’m having trouble hearing you, it’s very noisy outside (waiting area) and you have a soft voice, could you say that again please_ (M3).

5:1:4 Organisation of work within settings

In addition to the environmental context, the organisation of work across both antenatal clinics reflected similarly busy clinic areas with midwives multitasking throughout the day. The staff to booking visit ratio appeared the same at both sites; however the midwives’ perceptions of their working conditions differed. On the days that I attended the clinic to conduct observations, there appeared to be similar levels of activity across both sites in terms of the number of women booked to see any one midwife in either a morning or afternoon clinic. Typically, there were two to three midwives allocated for the morning or afternoon and with approximately six-eight women booked for an appointment.
5:1:5 Assessment protocols at settings

At both sites assessment and screening process had been established for over five years and a coordinated response was in place for women identified with risk factors for poor mental health.

There were differing protocols across both sites for dealing with partners or others accompanying a woman on her booking visit. At site A women were sent a letter asking them not to bring their partners to this first visit whereas, at site B partners were able to attend but were asked to leave. At site A, policy directives stated that partners and others were not permitted to attend the booking visit. The woman was provided with this information prior to her booking visit via a letter confirming her appointment. If partners or others did come to the antenatal clinic with the woman they were asked to wait in the waiting room for the duration of the visit. At site B partners are able to be present during the booking visit but are asked by the midwife to leave the room when the midwife conducts the psychosocial assessment and depression screening.

The local policy on partner/other attendance also impacted on recruitment to the study. For example, one couple I approached to participate on the study in the antenatal clinic, declined participation in the study and the woman commented ‘If he’s... (Pointing and looking at her partner) not allowed in, I don’t think you (the researcher MR) should be either’ (FN).

My observation and description of the environments where assessment and screening is conducted, was presented here, including assessment protocols and organisation of work within settings. The impact on women is not fully explored here as this section attempts to provide the reader with more detail of the environmental context and organisational issues regarding psychosocial assessment and screening. Some impact
on women is described in the following section and in Chapter 8. Reflections of my experience as a researcher undertaking observations where sensitive information is discussed and my response to these interactions is described in the following section.

5:2 Reflexivity

Ethnographic research is largely ‘reflexive’. This involves my reflections on the environmental and social process that may impinge upon or influence the data. I am required to have a critical attitude towards the data to and to recognise the factors that may influence the interpretation of the data and how it is conveyed in writing. Some of these factors are: the location of the setting, the sensitivity of the topic, power relations in the field and the nature of the social interaction between the researcher and the researched (Finlay and Gough, 2008).

When considering the impact of the researcher on the researched, ethnography tries to use a reflexive framework to understand the impact of the researcher’s perspective. The researcher needs to remain reflexive to their account of what is partial, selective and a personal version of the researched (De Laine, 1997). This includes the researcher’s own attitude changes, fears and anxieties, and social meanings when engaging in the field of the research. These factors can be influenced by the researcher’s background, professional orientation and personal history (Brewer, 2000).

As the researcher and also a mental health nurse, policy implementer and a woman, I needed to remain mindful of common interests yet remain reflexive around the impact of my reference points, and also, as an outsider to maintain professionalism as well. I describe some of my experiences of data collection and the emotional and professional boundaries that had to be managed while researching
sensitive topics. These are grouped into four sections: Entering the field and facilitating data collection, Environment, Sitting on your hands and keeping a straight face, Time to reflect. Within these descriptions are some field note data and descriptions of interactions to aid the description.

5:2:1 Entering the field and facilitating data collection

In order to gather ethnographic data, I had to observe the practice, behaviour and activity of participants (Hammersley & Atkinson 2010), relating to assessment and screening process. To do this I had to gain some level of confidence and trust with the participants to facilitate their comfort being observed by me. This required revealing enough information to establish a level of rapport and comfort with participants, whilst being mindful to be ‘the researcher’ and not a ‘mental health nurse’. It was necessary for me to approach the women in the clinic, the midwives on each shift and then coordinate visits with CFHNs. In the role of researcher I had to reflect on my communication style and continuously check how I presented myself, that is, was I ‘the researcher’ or was I ‘a mental health nurse’. Getting the balance right can be a challenging task as reported by others (Hammersley and Atkinson, 2010, Borbasi et al., 2005, De Laine, 1997).

As reported in Burns et al. (2012), nurse researchers may use different strategies, such as their appearance, to minimise the impact of observing in health care settings. One of the other ways I attempted to minimise the impact of my presence was to wear clothing that was subdued or dissimilar to that of the clinicians. It was important to take measures to minimise the impact of being seated in close proximity to the clinician and the woman being observed, whilst writing many notes. I used a pen that made less sound on the page such as a ballpoint and was mindful not to click the pen on and off to indicate the possibility of taking notes.
5:2:2 Environment

The antenatal clinic environment appeared to impact on women entering and leaving the clinic areas. Some women expressed to me their discomfort when attending site A antenatal clinic commenting:

*I can’t believe they make heavily pregnant women wait in that horrible, long, dark corridor* (W18)

Or;

*If I knew the chairs were going to be that bad I’d have brought some cushions with me* (W7).

In contrast women from site B perceived the antenatal clinic environment more positively describing it as ‘friendly’ and ‘inviting’:

*I thought it was really great, having the play area for the children and the waiting area was really big and bright and the midwives were so friendly, so yeah I thought it was a great environment, I was happy to wait my turn* (W23)

Women’s responses prompted me to consider the impact of environment on one’s experience when entering the clinic environments. Women appeared to make judgements about whether a service or a midwife was acceptable based on the visual feedback of the environment. At site B, the setting appeared to make women feel more comfortable and even confident in their midwife:

*‘I just saw all her pictures and thought yeah they looked like happy mums so she must be good this midwife’* (W11).

Further reflection led me to consider on a wider level whether health services and organisations placed value on the visual presentation of clinical settings and its
subsequent effect on women. It appeared to me that changes can be made to environments and help women feel more comfortable.

On occasions when entering women’s homes I felt like an intruder in home environments and provoked a level of discomfort for me. I reflected on whether CFHNs also feel a level of discomfort. However, this appeared not to be the case as CFHNs perceived entering women’s homes during universal health home visiting as part of their core business and described feeling comfortable ‘an everyday part of my routine’ (CFHN7). For me it felt like breaching a boundary somehow. I found it hard not to observe the woman’s environment and formulate judgements about the woman’s living conditions or if the conditions were suitable for them. The range for home visits went from eastern suburban terrace houses to housing commission dwellings in south western Sydney, with poorly kept yards, dogs, poor fencing and differing levels of cleanliness. In one house a snake was a family pet and I knew it was not a threat but I was disconcerted at the snake and concerned about safety issues for the baby and visitors. Entering women’s homes provides further detail on the women’s lives, and the CFHNs appeared to use this detail as part of their assessment as reported in Chapter 7 (Rollans, 2013b), I reflected on the necessity of home visits to understand the impact of the home environment on women. This is also reported in Chapter 8 (Rollans, 2013c), as women’s experience of surveillance.

5:2:3 Sitting on your hands and keeping a straight face

During some observations of interactions I experienced some tension between my role as an observer and researcher with my professional role as a mental health nurse. The types of questions asked by midwives and CFHNs evoked emotional responses in women and encouraged them to share their abuse histories or previous traumatic
events despite their distress. I felt at times the sense or urge to intervene but had to moderate this temptation and ‘sit on my hands’ so to speak.

The types of incidences that provoked this restrained response from me related to observing human errors or observing the asking and response to the questions during assessment process. Such as in the case of W17 where the midwife was entering incorrect information regarding domestic violence screening, recording it as a positive response instead of the accurate negative response, as reported in Chapter 8, (Rollans, 2013c). This experience required me to restrict or restrain any expression of confusion or dissatisfaction and minimise physical behaviour such as sighing or shifting in the chair during the observations.

Clinicians at times turned to me, as the researcher but simultaneously viewed me as the mental health nurse, seeking advice and guidance. This may be a response to seeing me as an ‘insider’, having similar knowledge of the area of psychosocial assessment or possibly more expert than themselves (Burns et al. 2012). At these times I was mindful to minimise communication and refer responses back to the midwife or nurse. This may have had some effect on the observational data, if at times the clinicians being observed were aware of my presence and were considering my reactions to their practice. Following the observation sessions some of the midwives and CFHNs asked questions such as; ‘So how did I do?’ (FN6), appearing to seek my approval. In these instances I would refer the questions back to the clinician asking; ‘How did you think you went?’ (FN6). It required restraint at times to not provide positive or negative feedback to the clinicians during interviews.

5:2:4 Time to reflect:
There is now growing acceptance that qualitative researchers investigating sensitive topics may need therapeutic support to assist them to deal with their own emotions
evoked by the women’s stories (Dickson-Swift et al. 2009). Supervision and debriefing following observations was something I undertook regularly with the supervisors in this study. Immediate supervision was required on a few occasions to discuss my responses to interactions observed between the clinicians and the women, for example; I was distressed at a CFHN’s response to a women disclosing discomfort around her newborn’s birth mark and when the CFHN first saw the birthmark she exclaimed. Observing a lack of sensitivity that midwives or CFHNs displayed towards women at times distressed me. I needed to consult my supervisors on various occasions to debrief and reflect on my experience of observing and my emotional responses.

Emotional and physical exhaustion may be the result of a researcher’s reactions to the data collected according to Dickson-Swift et al. (2007). Listening to women’s stories of traumatic birth experiences during interviews with women in the post natal period was infrequent; however it did occur on a few occasions. Women shared their birth experience with me if it had contributed to an incident that occurred during an interaction, such as the lack of sensitivity from a CFHN when a woman described her caesarean sections as being ‘attacked by a machete...’ (W12), as reported in Chapter 8 (Rollans, 2013c). This visual imagery of the woman’s description became ‘alive’ in my mind and had some impact on me. I was disturbed by the imagery created by the woman’s description and the CFHN’s lack of sensitivity, I felt angry toward the nurse for her lack of care and empathy.

Although, as an experienced mental health nurse, I had heard many disturbing and traumatic stories throughout my work experience, I was still not immune to the effect of hearing some of the women’s experiences whilst conducting this study. Hearing women’s stories would raise an emotional response in me that, at times,
required the support of the supervisors. Regular supervision provided by supervisors in this study, created a space for me to reflect openly about my experience as a researcher and assisted in the objective analysis of the data collected. During observations I analysed my experience, I feel this allowed me to get closer to the data and added depth to my understandings of the experiences of the women and of the clinicians.

5:3 Chapter conclusion

This chapter describes the environmental context where assessment and screening is conducted. Observations and reflections as a researcher which may have impacted on clinicians’ or women’s experience are also presented. The need to remain reflexive as an ethnographic researcher was important, my experience of hearing women’s stories and aspects of restraint that were required on my part when observing interactions were shared in this chapter. The following chapter presents the published paper regarding the findings from the antenatal observations of midwives conducting psychosocial assessment.
CHAPTER 6:
Findings: The process of psychosocial assessment and depression screening as conducted by midwives at the antenatal booking visit

6:1 Publication: relevance to thesis

Chapter 6 comprises the publication by Rollans, M., Schmied, V., Kemp, L. & Meade, T. (2012). 'We just ask some questions...' the process of antenatal psychosocial assessment by midwives (Midwifery). This paper presents the analysis of the findings regarding the process of psychosocial assessment as it is conducted by midwives in the antenatal clinic at the booking visit. Midwives were observed to vary their approach to psychosocial assessment. Some followed the structured format and delivered the questions in a directive manner, while others appeared more flexible in their approach, blending sensitive questions as issues were raised. Half the midwives observed modified the questions by rephrasing them to assist understanding. Sensitive disclosures by women were explored with empathy.
'We just ask some questions…’ the process of antenatal psychosocial assessment by midwives

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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.

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 coordinated 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...
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 n 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 publically 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

<table>
<thead>
<tr>
<th>Variables (risk factors)</th>
<th>Suggested format for psychosocial assessment questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Lack of support</td>
<td>1. Will you be able to get practical support with your baby?</td>
</tr>
<tr>
<td>II. Recent major stressors in the last 12 months</td>
<td>2. Do you have someone you are able to talk to about your feelings or worries?</td>
</tr>
<tr>
<td>III. Low self-esteem</td>
<td>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?</td>
</tr>
<tr>
<td>IV. History of anxiety, depression or other mental health problems</td>
<td>4. Generally, do you consider yourself a confident person?</td>
</tr>
<tr>
<td>V. Couple's relationship problems or dysfunction (if applicable)</td>
<td>5. Does it worry you a lot if things get messy or out of place?</td>
</tr>
<tr>
<td>VI. Adverse childhood experiences</td>
<td>6a. Have you ever felt anxious, miserable, worried or depressed for more than a couple of weeks?</td>
</tr>
<tr>
<td>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</td>
<td>6b. If so, did it seriously interfere with your work and your relationships with friends and family?</td>
</tr>
<tr>
<td>Opportunity to disclose further</td>
<td>7. Are you currently receiving, or have you in the past received treatment for any emotional problems?</td>
</tr>
</tbody>
</table>

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M. Rollans et al. / Midwifery \[\text{NSW Department of Health, 2009. NSW Health/Families NS}\

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**Table 1**

Questions used in psychosocial assessment in NSW.
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.

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

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.

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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 your first baby?’ (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.

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 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 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

| 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 |

| 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 |
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 ‘softer’ 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 woman ‘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 observing 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 (Ramsey 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. (2011) 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.

Acknowledgements

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Reference


6.2 Chapter conclusion

This chapter presented the paper 'We just ask some questions...' the process of antenatal psychosocial assessment by midwives, providing data that describes the process of psychosocial assessment as conducted by midwives in the antenatal clinic. The data focus on the greeting by the midwives, commencing the visit, the delivery of the questions such as the timing, approach and style undertaken by midwives. Overall most participating midwives demonstrated skill in psychosocial assessment. Modification of questions appeared to be adopted where assisting in the interpretation and comprehension of the questions is needed, however, it may reflect a level of discomfort on the part of the midwife in asking sensitive questions. To maintain this positive approach midwives require organisational support for ongoing training and clinical supervision. The following chapter presents the published paper regarding the findings from the postnatal observations made by CFHNS conducting psychosocial assessment.
CHAPTER 7:

Findings: The process of psychosocial assessment and depression screening as conducted by Child and Family Health Nurses (CFHNS) after birth

7:1 Publication relevance to thesis

Chapter seven present the publication by Rollans, M., Schmied, V., Kemp, L. & Meade, T. (2013b). Negotiating policy in practice: child and family health approach to the process of postnatal psychosocial assessment (*BMC Health Services*). This paper describes how the diverse ways that CFHNS approach assessment and screening. Four major themes emerged that represent the approach: ‘Engagement: getting that first bit right’, ‘Doing some paperwork’, ‘Creating comfort’ and ‘Psychosocial assessment: doing it another way’. CFHNS were observed to utilise other skills to help formulate clinical decisions.
Negotiating policy in practice: child and family health nurses’ approach to the process of postnatal psychosocial assessment

Mellanie Rollans1*, Virginia Schmied1, Lynn Kemp2 and Tanya Meade3

Abstract

Background: There is growing recognition internationally of the need to identify women with risk factors for poor perinatal mental health in pregnancy and following birth. In the state of New South Wales, Australia the Supporting Families Early policy provides a framework of assessment and support for women and families and includes routine psychosocial assessment and depression screening. This study investigated the approach taken by Child and Family Health Nurses (CFHNs) following birth to assessment and screening as recommended by state policy. This was a qualitative ethnographic study that included 83 CFHN and 20 women. Observations occurred with thirteen nurses; with 20 women, in the home or the clinic environment. An additional 70 nurses participated in discussion groups. An observational tool (4D&4R) and field notes were used to record observations and analysed descriptively using frequencies. Field notes, interview data and discussion group transcripts were analysed thematically.

Methods: This was a qualitative ethnographic study that included 83 CFHN and 20 women. Observations occurred with thirteen nurses; with 20 women, in the home or the clinic environment. An additional 70 nurses participated in discussion groups. An observational tool (4D&4R) and field notes were used to record observations and analysed descriptively using frequencies. Field notes, interview data and discussion group transcripts were analysed thematically.

Results: CFHNs demonstrated a range of approaches to assessment and screening. Psychosocial assessment was conducted in 50% (10 out of the 20) of the interactions observed; however, all the women were screened using the Edinburgh Depression Scale. Four major themes that represent the approach taken to the assessment process were identified: ‘Engagement: getting that first bit right’, ‘Doing some paperwork’, ‘Creating comfort’ and ‘Psychosocial assessment: doing it another way’. Nurses utilised other skills such as observing the women interacting with their baby, taking note of non verbal communication and using intuition to develop a clinical decision.

Conclusion: Overall, nurses’ took a sensitive and caring approach to assessment and screening, however, there were differences in interpretations of the policy recommendations across the two sites. Nurses adopt a flexible, relationship-based approach to the assessment process; however, they experience tension when required to incorporate structured psychosocial assessment processes. To undertake assessment and screening effectively, CFHNs require ongoing support, training and supervision to maintain this sensitive and emotionally challenging work.

Keywords: Psychosocial assessment, Depression screening, Child and family health nurses, Perinatal mental health, Postnatal depression, Domestic violence screening, Home visiting
Background
Psychosocial issues during pregnancy and early parenting are common and may have lasting effects with poorer outcomes for women and their families [1-3]. Prevalence of depressive symptoms or a diagnosis of depression ranges from 8 to 15% in the first year following birth [4] highlighting the need to identify and address psychosocial issues early [5]. The importance of early intervention has led to initiatives both in Australia and internationally to conduct routine assessment and screening of pregnant and postpartum women in order to identify those who may be at risk of adverse mental health outcomes.

All Australian states and territories provide universal child and family health nursing services free of charge to all children from birth to 5 and their families. In some instances CFHN will make contact with families in the antenatal period, although this is less common [6]. While the policy platform and schedule of services vary across states and territories, all offer routine monitoring of child development, health promotion activities focused on both children and families and the provision of support for early parenting and families [7]. Women are referred from the maternity service to the child and family health nursing service by midwives but as these services are generally not under the same management structure, there is little direct communication between CFHNs and midwives [8]. Levels of continuity of service and care provider vary greatly at both a state and local level. In all states and territories child family health nursing services are provided by registered nurses with specialist qualifications in child and family health nursing. Known in most Australian jurisdictions as child and family health nurses (CFHNs), they are similar to health visitors in the UK [9], child health nurses in Sweden [10] and plunkett nurses in New Zealand [11].

In the Australian state of New South Wales (NSW) the Supporting Families Early (SFE) policy and the Safe Start guidelines [12] formalised long standing practice that had been operating under draft guidelines since 2001 (IPC). This policy and guidelines outline the services to be provided to new parents to support child health and development in the postnatal period. A key recommended part of that role is assessment and screening for psychosocial risk, both antenatally and postnatally. This assessment is undertaken by midwives at the first antenatal appointment (around 12 to 14 weeks gestation) and by CFHN within the first six to eight weeks after birth. The policy recommends a structured assessment and screening process that incorporates a specific set of questions (see Table 1) and the use of the Edinburgh Postnatal Depression Scale (EPDS) [13], both before and after birth. The policy, however, also suggests that CFHNs take a flexible, partnership based approach to practice [12]. The tension between taking a structured approach to assessment and screening versus working in a flexible way has been raised by some commentators [9,14-16] who argue it is more appropriate to engage parents in a discussion of their needs.

These initiatives, whilst important in the detection of potential risk factors, place greater emphasis on midwives and CFHNs as the frontline clinicians, to increase their knowledge of social and emotional risk factors for poor mental health during pregnancy and after birth [17]. The dynamic interaction between the woman and the CFHN during assessment of social and emotional needs is still poorly understood and often unrecognised in practice [15,18]. Few studies have investigated the process of psychosocial assessment and screening in the postnatal period.

In this current study, the authors have examined the process and impact of psychosocial assessment and screening on both women and the midwife/CFHN conducting the assessment at two points in time, in pregnancy and after birth, as outlined in the NSW policy recommendation [12]. The findings of the observations of midwife-woman interaction during assessment and screening in pregnancy are presented in Rollans et al. [19]. This paper examines the approach (actions and interactions) that CFHNs take to conduct this psychosocial assessment and screening in the early postnatal period. The process of assessment and CFHNs role is examined in the context of the above debates and policy that requires both the use of structured tools and assessments but also a flexible, partnership approach to working with families. The study explored how the nurses negotiate and make sense of these two potentially contradictory approaches in practice.

Methods
This is an ethnographic study that was conducted in NSW, Australia between February 2011 and October 2011. Data was gathered from observations of CFHN-client interactions, brief interviews with the nurses following the clinical encounters and from five discussion groups conducted with CFHNs from the participating sites. Ethics approval for the study was obtained from the Human Research Ethics Committee in the two local health districts where the study was conducted and from the University of Western Sydney. The qualitative component of this manuscript adheres to the qualitative research review guidelines (RATS).

Setting
The study was conducted in two local health districts in NSW. These sites were selected because the assessment and depression screening processes had been in place in the antenatal period for over five years; however, implementation of assessment following birth was more recent in both sites. Both sites underwent updates their processes in order to align with the new SFE policy. The two sites differed with regard to the timing of depression screening and psychosocial assessment. At site A, CFHNs ask
women to complete the EPDS at the home visit that occurs within two to four weeks after discharge from hospital; whilst at site B, CFHNs screen with the EPDS when the woman visits the clinic six weeks after birth.

**Participants and recruitment**
A total of 83 CFHNs and 20 women agreed to participate in the study. Of the 83 CFHNs, 13 were observed during their interaction with the 20 postnatal women and 70 additional nurses participated in discussion groups. Both the CFHNs and the women were recruited prior to the birth. Women were recruited in the antenatal clinic. In order to observe the same group of women interacting with CFHNs after birth, CFHNs were informed about and recruited to participate in the study through a series of in-service sessions conducted by the researchers at each site. The women participants observed after birth had also been observed in the antenatal booking visit. Women were excluded from the study if they were under 18 years old or required an interpreter. After birth, women participating in this study were linked to a consenting CFHN, who was to conduct the home visit or the six week clinic visit, at which time the first author (MR) was present to observe the interaction.

All CFHNs working in these two sites were also invited to participate in a discussion group. Information about the discussion group was presented at the in-service sessions and consent was obtained at the start of the group.

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**Table 1 Psychosocial assessment and questions**

<table>
<thead>
<tr>
<th>Variables (Risk factors)</th>
<th>Suggested format for psychosocial assessment questions</th>
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</thead>
<tbody>
<tr>
<td>I. Lack of support</td>
<td>1. Will you be able to get practical support with your baby?</td>
</tr>
<tr>
<td></td>
<td>2. Do you have someone you are able to talk to about your feelings or worries?</td>
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<tr>
<td>II. Recent major stressors in the last 12 months.</td>
<td>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?</td>
</tr>
<tr>
<td>III. Low self-esteem (including lack of self-confidence, high anxiety and perfectionist traits)</td>
<td>4. Generally, do you consider yourself a confident person?</td>
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<td>IV. History of anxiety, depression or other mental health problems</td>
<td>5. Does it worry you a lot if things get messy or out of place?</td>
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<td></td>
<td>6a. Have you ever felt anxious, miserable, worried or depressed for more than a couple of weeks?</td>
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<td></td>
<td>6b. If so, did it seriously interfere with your work and your relationships with friends and family?</td>
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<td></td>
<td>7. Are you currently receiving, or have you in the past received treatment for any emotional problems?</td>
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<td>V. Couple’s Relationship Problems or Dysfunction (if applicable)</td>
<td>8. How would you describe your relationship with your partner?</td>
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<td></td>
<td>9. a) Antenatal: What do you think your relationship will be like after the birth?</td>
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<tr>
<td></td>
<td>OR</td>
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<tr>
<td></td>
<td>b) Postnatal (in Community Health Setting): Has your relationship changed since having the baby?</td>
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<tr>
<td>VI. Adverse childhood experiences</td>
<td>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)?</td>
</tr>
<tr>
<td>VII. Domestic violence (DV) 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</td>
<td>11. Within the last year have you been hit, slapped, or hurt in other ways by your partner or ex-partner?</td>
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<td></td>
<td>12. Are you frightened of your partner or ex-partner? (If the response to questions 11 and 12 is &quot;No&quot; then offer the DV information card and omit questions 13–18)</td>
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<tr>
<td></td>
<td>13. Are you safe here at home/to go home when you leave here?</td>
</tr>
<tr>
<td></td>
<td>14. Has your child/children been hurt or witnessed violence?</td>
</tr>
<tr>
<td></td>
<td>15. Who is/are your children with now?</td>
</tr>
<tr>
<td></td>
<td>16. Are they safe?</td>
</tr>
<tr>
<td></td>
<td>17. Are you worried about your child/children’s safety?</td>
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<tr>
<td></td>
<td>18. Would you like assistance with this?</td>
</tr>
<tr>
<td>Opportunity to disclose further</td>
<td>19. Are there any other issues or worries you would like to mention?</td>
</tr>
</tbody>
</table>
The professional experience of the participating CFHNs ranged from one year to over 20 years. The average age of the CFHN participants was 51 years, ranging from 28 to 62 years. Of the 13 CFHNs that were observed, eight had greater than five years experience. All the CFHNs were employed in universal services, with 47% fulltime employees and over half (51%) working part-time, one casual CFHN was observed during interactions. All of these CFHNs were registered nurses with specialist qualifications in CFHN either as post registration certificate or post graduate certificate or diploma. Although all 83 CFHNs had recently received family partnership training (Davis & Day 2010), only 40 percent of the CFHNs reported that they had received training in psychosocial assessment and depression screening including the use of the EPDS and domestic violence screening. Mandatory online training was available however, few CFHNs had completed this at the time of data collection for this study.

On average the women who participated in the postnatal component of this study were 30 years of age, ranging from 22–41 years. Of these 20 women, over half (14 out of 20) were born in countries outside of Australia, with 11 born in non-English speaking countries. Of these 20 women, nine were having their first baby. The participants were well educated with 19 of the 20 women having university level qualifications. All of these women were either married or living in de facto relationships.

Data collection
Data collection included observations of interactions between CFHNs and new mothers, brief interviews with the CFHNs following the visit and discussion groups with nurses.

Observations
Non-participant observations of interactions between CFHNs and new mothers were conducted at either the home visit conducted by the nurse two to four weeks after birth or in the centre-based visit conducted by the nurse at six weeks after birth. This difference in time points of data collection was unavoidable due to varying approach taken to the implementation of Safe Start policy in each site. Observations occurred between 11 women and seven CFHNs at a home visit and nine observations were conducted at the six week clinic visit with 6 CFHN. The researcher (MR) completed field notes and reflec-tive nature of the content in these discussions but the interactions were not audio-recorded due to the sensitive nature of the content in these discussions but the field researcher (MR) completed field notes and reflections shortly after observations while drawing on 4D&4R data as a prompt for those notes.

Interviews
Brief interviews were conducted with the participating CFHNs directly following the observation. These lasted approximately five to ten minutes obtaining the CFHNs 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 also not audio-recorded.

Discussion groups
Two discussion groups were facilitated from at site B and three discussion groups at site A with CFHNs who conduct psychosocial assessment and depression screening to identify their perceptions and experiences of undertaking psychosocial assessment, beliefs about the nature of the relationship they develop with women/families, training and perceived skills required to undertake psychosocial assessment, their experience of working in multidisciplinary teams and how these services influence outcomes for families (key prompts listed in Table 2). Each group had between 10 to 25 participants, lasting approximately one hour and with the participants’ permission were digitally recorded and transcribed verbatim with all identifying material removed.
Table 2 Discussion group questions

Discussion group questions CFHNs

1. Can you tell us about your experience of conducting Psychosocial assessment and depression screening:
   a. Do you use the SS Q’s?
   b. Do you use the EPDS?
   c. Prompts – can you recall how you felt when you had to ask these questions the first few times?
   d. How do you feel about doing it now?
   e. How do you feel about asking the domestic violence screening questions?
      Are you comfortable with the wording?
      (Maybe) Do you think there could be a different approach to these questions?
2. How do you think women are prepared for what is entailed in the home visit?
   a. What do you hope to achieve in the first home visit?
3. What has helped you to incorporate psychosocial assessment and depression screening into your practice?
4. What challenges have you or your colleagues faced?
5. What are your views on conducting depression screening with the EPDS? In your experience what have you found to be the best way to use the EPDS?
   a. (Prompt) for example in what part of the interview you would ask the woman to complete the tool. Once the woman has completed the tool and you notice it is high – how do you address this with women
6. I am also really interest in how you might use your clinical judgment in the process of assessment - Can you describe for me the cues that give you a hunch, about something
   E.g. Strong sense something’s not right, don’t get responses or get the opposite what expecting
7. In what way has your practice changed since you have been incorporating these assessments in your practice?
8. What, if anything, do you feel has prepared you for working in this way?
9. What training and support have you been offered and what have you participated in for screening and assessment?
10. How do you perceive the use of computers will affect this process?
11. Is there anything else you would like to add?

Data analysis

The data recorded on the observation tool (4D&4R) was analysed using content analysis [20] and is reported using frequencies. The following questions were used to guide the analysis: how did the CFHN 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.

Field note data from the observations and brief interviews with nurses and verbatim transcripts of the discussion group were analysed thematically. The first step in the analysis involved multiple readings and re-readings of the data and listening to the recordings to become immersed in the data [21]. This was followed by identification and labelling of concepts in the data and development of preliminary themes from these concepts. These themes are captured in phrases that where appropriate use the language of the participants. This was an iterative process which involved all researchers discussing the concepts, themes and relationships during the preliminary analysis. Emerging themes and the accompanying data were discussed with the co-authors to ensure reliability of the coding. Concepts and themes were constantly compared with other themes and refined [21]. This process resulted in the identification of four major themes.

Results

The analysis of observation, interview and focus group data indicated a range of approaches to the psychosocial assessment and depression screening in the postnatal period. The content analysis of the data recorded on the observation tool is presented first, reporting the frequency of assessment and screening. This is followed by a detailed explication of the four major themes that describe and interpret the approach that CFHNs take to assessment and screening. The identified themes are: ‘Engagement: getting that first bit right’, ‘Doing some paperwork’, ‘Creating comfort’ and ‘Psychosocial assessment: doing it another way’.

Frequency of psychosocial assessment and screening

Analysis of data recorded on the observation tool describes how often the nurses conducted the structured assessment in line with the guidelines/policy. Table 3 provides a summary of the frequency of psychosocial assessment and depression screening by nurses in the 20 observed clinical interactions. In all (20 out of 20) of the observed interactions, the CFHN used the EPDS to screen for possible depression, asking the woman to complete the EPDS herself (18 out of 20) and in two situations where the woman’s English was limited; the CFHN read the questions out to the woman.

In contrast, only one nurse at site A undertook the structured psychosocial assessment as recommended by the SFE policy, while at site B, the assessment was completed in each of the nine observed interactions. Some nurses at site B used the previous assessment form, as the forms that accompanied the Safe Start policy were still in the ‘roll out’ phase; while others had adopted the Safe Start questions. In six out of the 10 occasions where the psychosocial assessment was conducted, the CFHN asked the woman the questions directly and on four occasions the woman was asked to complete the questions herself. Only one woman sought clarification when the questionnaire was self administered.
At site A, screening for domestic violence was conducted on four occasions and at site B, all the CFHNs undertook domestic violence screening as outlined in the policy. Where the woman’s partner was present in either the home or clinic setting; the CFHN organised private time with the woman so no others were present. In eight out of the 11 home visits observed there was either a partner or others present. On seven occasions the CFHNs did not ask the questions if there was another family member present or at home in the house. However, on one occasion the CFHN was confident that the woman’s partner could not overhear, so she asked the domestic violence questions. In the brief interview following this observation, the CFHN indicated that she had observed some tension between the woman and her partner which she believed may have indicated some interpersonal conflict and control. The following was recorded in field notes (FNW2):

The CFHN reported that the husband appeared to dominate the conversation that she was trying to have with the woman and was ordering the woman to complete tasks whilst the CFHN was present. The husband had answered for the woman when the CFHN asked routine questions of her, therefore, the

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<th>Participant no.</th>
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CFHN stated that she wanted to explore this relationship dynamic further and the impact this had on the woman.

In the more formal clinic context (nine out of 20 observations) if others were present, as was the case in three out of nine occasions, the CFHN was able to ask the partner or others to leave the room while the screening was completed. It is also evident that nurses’ comfort with screening for violence influenced practice (nurses’ views on this are addressed below). At site B on the nine occasions when the nurse did assess for domestic violence, these questions immediately followed the psychosocial questions.

**Engagement: getting that first bit right**

In this study 19 of the 20 observations of nurse-client interactions represented the first encounter between the participating CFHN and the new mother. At the start of the interaction most nurses appeared to prioritise establishing a rapport with the woman by showing respect for the woman and others present, introducing herself, and negotiating where and how the visit should proceed. For example, in one home visit, the CFHN sought
permission as to where to ‘set up’ in the following way ‘...hello are you...I’m (CFHN introduces herself) from the clinic...where would you like us to go...can we set up my scales here, can we set up on the table?’ (CFHN3). Encounters in the home appeared to also be influenced by who was present (other children and family members) or whether the baby was feeding, awake or asleep. In this context nurses were observed to be less formal:

CFHN1 - ‘Hello, how are you? Sorry did we drive your visitors away?’
W1 – ‘They had to go anyway’
Father 1 - ‘Would you like a cup of tea or something?’
CFHN1 - ‘No thank you, I’m alright. (Turns to the woman) We need to do some paperwork and baby check, is she (baby) sleeping? Do you want to do the paper work first?’

In contrast, the clinic environment generated a more formal atmosphere with the prearranged seating directing where the woman and others with her would sit. In this context, CFHN attempted to create a degree of informality by ‘chatting’ with the woman. One nurse for example, started the encounter in the following way: (CFHN11) – ‘Hi, how you going’, the woman responded by asking the CFHN how she is; who then shared her story of the difficulties experienced getting to work that morning ‘I’ve had one of those mornings...’ (CFHN11). This appeared to put the family at ease as they laughed and enjoyed the CFHN light heartedness as was noted in field notes (FNW14). In both settings, in this initial effort to build rapport with the woman, CFHNs were also observed to use compliments, particularly about the baby, ‘she’s so very beautiful isn’t she’ (CFHN1) or and humour ‘you’re not ready to give him up yet (laughs)?’ (CFHN2). These actions were congruent with how nurses talked about the importance of the introduction to the visit in the discussion groups;

‘It’s so important you know getting that first bit right. They’re checking you out seeing if you’re good enough and if they can trust you. So it’s really important how you introduce yourself and what needs to be done.’ (DG3)

It was also common at this time for the CFHN to introduce what would occur in the overall visit and then to enquire as to how the woman may like to proceed. For example one nurse stated, ‘there are three things we do, the baby check, answer any questions you have and then we do the check up to see how you’re going (looks up to face the woman). What would you like to do first’ (CFHN5) or ‘is baby asleep? Ok shall I just talk to you then...?’ (CFHN4).

Less commonly the CFHN appeared rushed or did not appear to take the time needed to establish rapport as evident in this interaction: (Nurse greets the husband at the door) ‘Hello how are you? Is (Woman’s name) home,’ (Immediately followed by), ‘Have you got somewhere where there’s a bench where I can take the scale? Is it okay to do the baby check?’ (CFHN11).

Although most of the nurses had not met these women before; on several occasions it was observed that the CFHNs had some information about the woman and her family through the referral received from the maternity services. In two instances the CFHN had received information about the woman’s history of mental health problems and domestic violence and raised these issues with the women stating, ‘It says here that last year you went through a bit of depression, is that true?’ (CFHN12). Access to or lack of information was also discussed by CFHNs in the groups, ‘9/10ths of the time you know what you’re going into’ (DG1). However, other CFHNs indicated they were not ‘forewarned; sometimes you don’t know what you might find’ (DG2). When information was provided, the CFHNs tended to feel prepared or ‘well equipped’ (CFHN11) to undertake the visit and were aware of issues where further exploration may be needed.

‘Doing some paperwork’
The phrase ‘doing some paperwork’ was used commonly by nurses when they were providing women with an overview of what would happen in the visit or when they introduced the psychosocial questions and depression screening.

The introduction to and the delivery of the psychosocial assessment and depression screening varied and the participating nurses’ demonstrated capacity to adapt to the context and the needs of the individual woman and family situation. This adaptation occurred despite the fact that nine out of 10 assessments occurred in the more formal clinic context. The assessment questions and screening tools were introduced at varying points in the consultation depending on the woman and the baby. For example, some CFHNs mentioned the assessment and screening, albeit in a ‘roundabout’ way, at the beginning of the visit, ‘we just need to do some paper work and check her’ (CFHN1) and then at the time of administering the questions a further explanation would be provided ‘we might do some screening just a few bits of paperwork...’ (CFHN13).

In the majority of observations (16 out of 20), the EPDS was introduced by the CFHN prior to administering it. In the other four observations the EPDS was not introduced but rather handed to the woman for her to complete without providing a rationale. A common approach to introducing the EPDS was first to remind the woman that she had...
completed the same questions at the booking visit in the antenatal period (12 out of 20) ‘...you would have done one of these at the hospital, it’s the Edinburgh Depression Scale’ (CFHN1). However, others simply emphasised, ‘...we routinely do it...we do it on everyone’ (CFHN1).

The EPDS was most typically introduced at the time in the interaction when the nurse wanted the woman to complete it and on only four out of 16 occasions did a CFHN discuss the rationale for this screening tool during the introduction to the visit stating for example;

...we firstly screen your baby and we also have a screening tool for you to at this visit. This is to learn a bit more about how you’re feeling so we do check the baby but we want to see how you’re feeling to; is this okay? (CFHN7).

At times the CFHNs were observed to modify or talked about modifying the questions on the EPDS. This occurred in situations for example, where the woman spoke little English as demonstrated here where the CFHN modifies question 2 of EPDS, ‘I have looked forward with enjoyment to things’ to ‘when you wake first thing in the morning you say, okay I’m going to do this, this and this okay, so let’s do it’ (CFHN3). On another occasion, the woman was offered a translated version of the EPDS in her first language, Arabic; however, she appeared to have difficulty reading the questions. The woman declined the translated instrument preferring the local referral pathways to mental health services. The CFHNs were less positive about local referral pathways to mental health services.

Creating comfort

Most of the CFHNs perceived it was important to ask women the psychosocial questions and to conduct screening for depression and domestic violence ‘...if you don’t ask you will never know’ and as a ‘...opportunity for women to discuss any concerns, if they wish’ (DG1). There appeared to be mixed views on the impact of these questions on the women. Some CFHNs were concerned that the questions may ‘shock’ or ‘surprise’ women or that the questions may be ‘confronting’;

When you look at your DV [domestic violence] questions or say the Safe Start questions, they’re incredibly confronting, whereas EPDS is, I think, is not anywhere near as confronting ... (DG3).

To minimise the impact of the delivery of these questions, CFHNs used a range of strategies, they recognise the importance of creating comfort, allowing time for the woman to feel comfortable and providing practical and emotional support. To create comfort for both the woman and themself, one CFHN described;

presenting the questions in the most comfortable way as you can in order for them to reflect or give them the opportunity, to say something; because some people have never spoken about it before (DG2).

The CFHNs also described giving time to this process and allowing women time for discussion ‘sometimes it takes a whole hour and then she’ll open up’ (DG2) aids in establishing rapport and creating comfort. At site A, CFHNs described how they ‘weave them (the psychosocial assessment questions) into the
conversational so it becomes a part of the conversation’ (DG3), for example; ‘do you have practical support with your baby?’ is woven into the conversation as ‘… your partner does your partner help you?’ (CFHN14) or ‘Are your family living close by?’ (CFHN10). However, CFHNs described this conversational approach developed with ‘practice, familiarity and more experience’ (DG3).

Another strategy used by CFHNs to create comfort was providing positive appraisal to women about how they were approaching or caring for their baby. For example, they may deliver forms of encouragement or positive reinforcement ‘look at you, holding him up close and stroking him, it’s automatic, you’re doing very well’ (CFHN7) ‘you’re a natural’ (CFHN13). This also included assessing elements of the woman’s emotional state and affect towards the baby as in this example with a woman following disclosure of a recent trauma such as a difficult labour experience ‘after that experience how was it then, that very early time when she was born, how did you feel about her then?’ (CFHN5).

It was also evident that the CFHNs needed to also create comfort for themselves. Nurses in this study reflected on their own personal life experiences and the impact this may have on the process of asking the psychosocial assessment questions ‘you might have had some of those experiences yourself and you might not feel comfortable asking a complete stranger about it because it may bring things up’ (DG2). In discussion groups some CFHNs disclosed that they were uncomfortable with specific questions. For example, some found asking the women about whether they had a history of child sexual abuse was the most challenging question to ask. In the observations with these nurses this question was asked on few occasions where psychosocial assessment was conducted, for example; ‘I feel a little bit uncomfortable sometimes when you have to stare at a woman and say – have you ever been abused?’ (DG3). One nurse noted that it required effort to ask this question ‘the sexual abuse questions are harder for me to spit out…’ (DG2). Other CFHNs modified their practice, leaving the sexual abuse in childhood question and only asking it if they received a positive response to one of the domestic violence questions. However, they also suggested that familiarity was one way to overcome this challenge as described by a participating CFHN;

At first I was so scared when I got a yes to the sexual abuse question; what I’d do with this question… the more times I do it, the more relaxed I am (DG3).

It appears that the need to create comfort for the woman and for themselves, may have led some CFHNs to adopt a different approach to assessment.

**Psychosocial assessment: doing it another way**

During discussion groups and in observing CFHNs practice, it appeared nurses utilise other skills, other than asking recommended, structured questions, to assess women’s social and emotional wellbeing. In the home environment, at the home visit (as illustrated in Table 3), only one nurse conducted the structured psychosocial assessment, only four asked the domestic violence questions but all used the EPDS. During the groups, CFHNs discussed how they assessed women at the home visit in other ways. They emphasised using a range of skills and all of their senses to assess women. This appeared to arise out of the belief that the tools for assessment and screening may be limiting if the only approach used to assessment. As expressed here ‘they’re tools (Safe Start questions and EPDS)... that is all... it’s not a diagnosis’ (DG1). The subthemes included in this theme ‘Doing it another way’ are: Cloaked in the baby check; gathering information, seeing, hearing, thinking; and having a ‘sixth sense’.

**'Cloaked in the baby check’**

CFHNs consider the woman’s perspective is paramount ‘mum’s come first’ (DG3). They are mindful that ‘they [the women] are not expecting questions to do with them… their psychosocial… or their depression. They’re only focussed on the baby… that’s what they think we’re there for - the baby check.’ (DG3). CFHNs are aware that they are present in the woman’s home or in the clinic setting ‘cloaked in the baby check’ but always in their mind they are aware that they have another agenda; that is the need to undertake a social and emotional assessment of the woman and her family. CFHNs at both sites were observed to be gaining information about the woman’s emotional health and well being in other ways than the structured assessment process.

It appeared the CFHN assessed the woman on how well she was coping with being a new mother by examining the baby’s progress in terms of growth and physical development. For example, this CFHN describes not needing to ask the psychosocial questions because the baby was ‘Good on the numbers[baby weight]… so I had no alarm bells… she’s obviously doing really well’ (CFHN1). In another example in the interview with the nurse following the observation, the CFHN expressed her concerns to the researcher about the woman based on the assessment of the baby ‘I am honestly worried about her [the woman]; he [the baby] is quite small and not attaching at the breast, and she hasn’t been out of the house for 5 weeks – I want to see her again’ (CFHN7).
Gathering information - seeing hearing thinking

The nurses’ assessment of the woman and any ‘risk’ to the infant also included observing the home environment. For CFHNs, the appearance of the environment reflected the woman’s level of coping with everyday activities and being a mother. For example, one nurse commented that as she arrived at the house she would observe, ‘the car parked in the driveway and if there is a [safety approved] car seat in’ (DG2) suggesting she was observing for safety issues. Another nurse talked about her general assessment of the home environment noting whether ‘...the clothes were like up to the ceiling, I’m thinking this doesn’t look very good... then she [the woman] told me it’s her eighth baby... it’s my washing day today... so there’s nothing wrong with what I saw’ (DG2).

Nurses were also observed to use individually tailored questions that they believed could ascertain if there were social or emotional issues that needed to be addressed, for example;

I always ask them if they’re going to have another one (baby) following another one (baby) – it’s my standard question- if they say ‘yes’ then you know they’re doing alright if they say no ‘no more’ then I know there’s something not right (CFHN3).

Intuition

One of the participants described ‘using all the senses, sounds, smell, everything’ (DG2) as she considered or took in all aspects about the woman. Others elaborated on this idea talking about the women’s body language ‘...the moving in the seat, the lack of eye contact at that moment. I suppose you get a sixth sense to maybe probe a little deeper’ (DG1). The idea of having a ‘sixth sense’ and its value in assisting clinical judgement was emphasised by other CFHNs who described how they used their ‘intuition’ to assist them in identifying women who needed more time around emotional issues. ‘It’s not written on their foreheads, maybe she looks happy in front of you and then she starts crying and she’s like a completely different person. You’re like ah that’s why it didn’t feel right.’ This was also described as an ‘inkling’ ‘it’s their body language and how they’re using their words and what their communicating to you, that you get an inkling that something’s not quite right’ (DG3). Some CFHNs described how they altered their practice in order to attend to the woman’s needs once their ‘sixth sense’ had determined that the woman needed some additional support:

I’ve walked into a house and you can just see that she’s stressed... You say you’ve got a lot on your plate at the moment... let’s just stop right there we’ve got something more important to deal with. We can go back to the baby later (DG2).

Discussion

This study examined how CFHNs in NSW undertake psychosocial assessment in the context of the current policy and guidelines requiring both the use of structured tools to determine the psychosocial needs of families following birth, and a flexible partnership approach. Most participating nurses were observed to interact with women and families in a sensitive and caring way and showed a genuine interest in them and their infant. However, the study found varied interpretation of the SFE policy [12] in local practice. Only half of the participating nurses were observed to undertake the structured psychosocial assessment and in all but one case this occurred at site B in the clinic setting suggesting that the service location and/or time point for assessment (2–4 weeks in Site A in the home, Site B at approximately 6 weeks in the clinic) impacts on the way the assessment is delivered. At site A nurses described, both in interviews and in the discussion groups, that they gathered information about a woman, her infant and the family’s needs in other diverse ways. These differing approaches did not apply to the use of the EPDS to screen women for depressive symptoms, which nurses across both sites undertook with ease. It may be that the differences are due to the levels of integration of the new assessment policy rather than the difficulties with the tasks per se as screening for depression is a well established practice. Only a few nurses performed domestic violence screening and reflected in the discussion groups their discomfort and difficulties in undertaking this aspect of the assessment. They were similarly uncomfortable asking questions about sexual abuse. Variations in assessment processes have also been observed by Appleton and Cowley [22].

The vast majority of nurses observed in interaction with women demonstrated a genuine regard for women and their families and a capacity to work in partnership [23], even if they may only see the woman and family on this one occasion. Analysis of the observation data showed how nurses want to build rapport and do what Chalmers and Luker [24,25] first described as ‘entry work’ to negotiate the clinical encounter in order to successfully undertake psychosocial assessment [26]. Participants described that their success in gaining entry or not, relied on how they are perceived by families in the initial encounter. Being seen as warm, caring and genuine with a flexible approach, was more likely to facilitate the opportunity to conduct the assessment [8,26-29]. These engagement strategies were observed in the non-verbal and verbal communication of CFHNs such as smiling at the woman, complimenting her on the baby
and her mothering and negotiating with her as to how best to commence the visit. This projection of optimism by the nurse is described as an initial phase of interaction and was also observed in public health nurses in Canada interacting with women [28]. The nurses also conveyed a happy and friendly disposition at the onset of contact with the woman sending a message of the nurse being easy going and that the rest of the assessment may consequently go well. This also assisted in establishing initial rapport with the women [28]. This sensitivity to the commencement of the visit establishes a sense of attunement to the woman which Oberle and Tenove [30] describe as a discrete balance between the nurse and the woman. Over time this sensitivity to women assists the CFHN to attune to their strengths, capacities and vulnerability or potential risk [30].

However, it is evident that nurses experienced a dissonance or tension, being cognisant of the need to work in partnership with women and families, demonstrating a high level of respect and genuineness [23] for families, while at the same time responding to the mandate to assess for risk in a structured, population-based approach. Some nurses were also aware that this tension or confusion may also be experienced by families who believe that the nurse is focused on ‘checking’ the baby and then subsequently discover the nurse is also monitoring the progress of the mother by asking sensitive and intimate questions to determine the mental health and well being of the woman [31]. Nurses in this study guarded against this by ‘loaking’ the assessment in the baby check and downplaying the assessment as ‘doing some paperwork’.

One of the central findings of the study is the way in which many of the nurses at both sites were observed and reported taking a more flexible approach to assessment. To gather a ‘full picture’ about a woman and family, the CFHNs described using a range of skills to assess a woman’s needs which at site B were in addition to the structured questions and at site A were instead of these questions. For example, participants used the assessment of the baby and the mother-baby interaction as a way to ‘tap’ into a mother’s well being and how she is managing in her role as a mother of a new baby. The notion of doing the psychosocial assessment in another way has also been reported by Armstrong and Small [32] who found that maternal and child health nurses relied on their own assessments which often overrode protocol. The complex interactive occurrence of other processes occurring at the same time as routine assessment such as clinical judgement can be supported in this context and is under reported [33].

Nurses used observation skills to take in the environment as well as intuition where they drew on extensive clinical experience to carefully attune to the non verbal messages given by the woman and others present. This was captured by one nurse in the phrase, ‘seeing hearing thinking’. Wilson [34] describes this as a comprehensive form of ‘health surveillance’ but cautions along with others [31,35] that what is mostly considered a routine and unproblematic aspect of CFHN practice, may in fact be interpreted by women and families as a form of State control and regulation. This level of surveillance can occur in both the home and the clinic setting but it is largely unknown what impact this has on women [36].

In an attempt to reduce the impact of surveillance Jack et al. [31] describes that health professionals must work at assisting families to overcome fear, enabling a trust relationship to develop and to identify mutual or common ground. However, the other response that may occur is over compliance on the part of the woman to accommodate the nurse and to seek a relationship with the nurse [34]. In this study, nurses acted to both establish a relationship but also conceal the full purpose of the visit. Both the ‘engagement work’ of the nurse and the engagement by women and families raise ethical issues about the actual intent of the service, what families are seeking and most importantly, how this is achieved and how boundaries are established in the developing relationship [37]. This was echoed by Kardamanidis [27] who found in interviews with CFHNs providing sustained nurse home visiting, that women were more likely to disclose sensitive information when time was taken to build a trusting relationship than if simply asked a series of prescribed questions. Although there was some evidence of adaptation of psychosocial assessment processes in response to women with limited English, for example; modification of EPDS, the issues of conducting psychosocial assessment across cultures and building relationships with women who require language support, however, remains unresolved.

Some studies [32,38] suggest that women prefer to talk with a professional about their concerns or worries rather than complete a questionnaire. Similarly nurses also appear to prefer to talk with women and to make assessments about their mental health and well-being by using clinical judgement informed by gathering information in a range of ways, one of which might include a screening tool. Nurses in this study chose to adopt a more relational approach to assessment where they monitor for social cues and recognise the importance of building a relationship with families and that it is on the basis of this relationship that they are able to effectively assess the needs of women. This practice is consistent with that recommended by Cowley and Houston [39] who reject a structured format believing that it does not allow for the flexibility required to elicit sensitive information and suggest that these issues should be uncovered by the health professional during their ongoing contact with a woman. Nurses described observing the non verbal and verbal cues given by women and that they effectively
‘monitor’ women’s response in order to manage any distress [40].

Overall, nurses found this work challenging and described in the discussion groups that there were aspects of the assessment that they felt uncomfortable with for example screening for domestic violence and asking about child abuse. Other researchers [39,41] have raised concerns about the level of skill and the approach used by health professionals when conducting assessments related to obtaining sensitive information. Many CFHNS in this study felt they are inadequately prepared to undertake psychosocial assessment and have limited skills in eliciting and responding to sensitive information and the needs of women and families [40,42]. To manage CFHNS discomfort whilst introducing assessment, in this study CFHNS reported ‘cloaking’ psychosocial assessment in the baby check and ‘doing some paperwork’. These findings suggest that services need to invest in ongoing training, support and supervision for CFHNS to improve their skills and confidence in relating the purpose of assessment to families.

Study limitations
This study is based on small numbers of observations but provides a richness of qualitative data that may not be generalised, but the commonality of themes expressed by participants suggests similarity in the experience [43]. The sample included experienced CFHN, who may have felt more confident to participate in the research, and women who have received a university level of education. The sample thus may not reflect the general population of women using the service or CFHN providing the service. This may have impacted on the interaction. This study was also conducted across two sites that differed in both the location where assessment was conducted. Home versus clinic and at two different points in time, 2 weeks versus 6 weeks following birth. Some of the differences in interaction that were observed may have therefore occurred because the infant was 2 weeks versus 6 weeks old or because of the location.

Conclusion
This study explored the approach that nurses take to psychosocial assessment and depression screening in the context of the current debates and policy that requires the use of structured tools and assessments together with a flexible, partnership approach to working with families. The nurses managed this tension in two ways, first by doing the paperwork and second, in some instances by doing the assessment in an unstructured way using their observational skills and intuition to inform a clinical judgement. Whilst the use of structured assessment together with a partnership approach is consistent with best practice [44-46], nurses report it is challenging to work this way.

Abbreviations
CFHN: Child and family health nurse; SFE: Supporting families early package; NSW: New south wales; MR: Mellanie rollans; DG: Discussion groups; W: Woman; FN: Field note; PSA: Psychosocial assessment; EPDS: Edinburgh postnatal depression scale; DV: Domestic violence.

Competing interests
The authors declare that they have no competing interests.

Authors’ contributions
MR: Carried out the data collection, participated in the data analysis and the drafting of this manuscript. VS: Assisted in the design of the study, participated in the data analysis and the drafting of this manuscript. KK: Assisted in the design of the study, participated in the data analysis and the drafting of this manuscript. TC: Assisted in the design of the study, participated in the data analysis and the drafting of this manuscript. All authors read and approved the final manuscript.

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**7:2 Chapter conclusion**

This chapter presents the postnatal observational data and data from discussion groups with CFHNs as a published paper titled, ‘Negotiating policy in practice: child and family health nurses approach to the process of postnatal psychosocial assessment’. This paper described the approach taken by CFHNs to psychosocial assessment in the postnatal period at 2 weeks and at 6-8 weeks and in two different settings, the home and clinic environments. Overall, CFHNs’ approach was sensitive and caring, however, the policy recommendations were highly interpretable across the two sites. CFHNs consistently adopted a flexible, relationship-based approach to the assessment process. However, they experienced tension when required to incorporate a structured psychosocial assessment process. Further support, training and supervision are required to assist CFHNs to maintain this sensitive approach in this emotionally challenging work.
CHAPTER 8:
Findings: Women’s experience of psychosocial assessment and depression screening during pregnancy and following birth

8:1 Publication relevance to thesis

Chapter 7 presents the publication by Rollans, M., Schmied, V., Kemp, L. & Meade, T. (2013c) titled ‘Digging over that old ground’: an Australian perspective of women’s experience of psychosocial assessment and depression screening in pregnancy and following birth. (BMC Women’s Health). This paper describes women’s experiences of being asked the psychosocial questions. Whilst most women found it acceptable, they felt surprise at the sensitive nature of the questions. Women who had a history of trauma or loss were distressed by retelling their experiences. Five key themes emerged, three of which ‘Unexpected – a bit out of the blue’, ‘Intrusive - very personal questions’ and ‘Uncomfortable - digging over that old ground’, describe the impact that assessment had on women. Women’s experience of assessment and screening appeared to be influenced by the approach the midwife or nurse had in dealing with the women’s disclosures. This is reflected in the two remaining themes titled: Approach: ‘sensitivity and care’ and ‘being watched’.
Digging over that old ground: an Australian perspective of women’s experience of psychosocial assessment and depression screening in pregnancy and following birth

Mellanie Rollans1, Virginia Schmied1, Lynn Kemp2 and Tanya Meade3

Abstract

Background: There is increasing recognition of the need to identify risk factors for poor mental health in pregnancy and following birth. In New South Wales, Australia, health policy mandates psychosocial assessment and depression screening for all women at the antenatal booking visit and at six to eight weeks after birth. Few studies have explored in-depth women’s experience of assessment and how disclosures of sensitive information are managed by midwives and nurses. This paper describes women’s experience of psychosocial assessment and depression screening examining the meaning they attribute to assessment and how this influences their response.

Methods: This qualitative ethnographic study included 34 women who were observed antenatally in the clinic with 18 midwives and 20 of the same women who were observed during their interaction with 13 child and family health nurses after birth in the home or the clinic environment. An observational tool, 4D&4R, together with field notes was used to record observations and were analysed descriptively using frequencies. Women also participated in face to face interviews. Field note and interview data was analysed thematically and similarities and differences across different time points were identified.

Results: Most participants reported that it was acceptable to them to be asked the psychosocial questions however they felt unprepared for the sensitive nature of the questions asked. Women with a history of trauma or loss were distressed by retelling their experiences. Five key themes emerged. Three themes; ‘Unexpected: a bit out of the blue’, ‘Intrusive: very personal questions’ and ‘Uncomfortable: digging over that old ground’, describe the impact that assessment had on women. Women also emphasised that the approach taken by the midwife or nurse during assessment influenced their experience and in some cases what they reported. This is reflected in the themes titled: Approach: ‘sensitivity and care’ and ‘being watched’.

Conclusions: The findings emphasise the need for health services to better prepare women for this assessment prior to and after birth. It is crucial that health professionals are educationally prepared for this work and receive ongoing training and support in order to always deliver care that is empathetic and sensitive to women who are disclosing personal information.

Keywords: Psychosocial assessment, Depression screening, Mental health, Women’s health, Postnatal depression, Domestic violence screening, Midwifery, Nursing
Background

International research has identified the potential for significant short and longer term negative health and social outcomes for women and their infants of poor mental health in pregnancy and after birth [1-4]. Increasingly, policy makers and practitioners emphasise the importance of early identification and the need to offer services and appropriate treatment to women and their families [5]. As a consequence, psychosocial assessment and depression screening is now recommended as part of routine clinical practice of midwives and nurses working in Australia [6] and is increasingly being implemented internationally [7]. Assessment of psychosocial risk factors such as domestic violence, substance misuse, past history of abuse or mental health concerns, lack of support, lower socio-economic status and a stressful pregnancy [8,9] has become a key component of routine antenatal and postnatal care for Australian women in the state of New South Wales (NSW). The aim of the State policy known as ‘Supporting Families Early’ (SFE) [5] is to identify women with known risk factors (see Table 1 for assessment domains and questions) and to provide women and their families with ‘appropriate information and additional appointments or referral’ [5] p.69. The assessment process includes screening for depressive symptoms using the Edinburgh Postnatal Depression Scale (EPDS), domestic violence screening and questions about drug use and previous or existing mental health issues (see Table 1).

The SFE policy recommends that women be assessed as a minimum, at two points in time: antenatal (approximately 20 weeks into pregnancy) and postnatal (within 1 year of giving birth). Assessment includes a psychosocial risk factors assessment and a detailed mental health assessment (using a structured diagnostic interview) when appropriate. The psychosocial risk factors assessment is conducted using a standardised form which includes questions about a range of domains, such as: lack of support, recent major stressors, low self-esteem, history of anxiety, depression or other mental health problems, couple’s relationship problems or dysfunction, and adverse childhood experiences. If a woman is identified as at risk in any of these domains, she is referred to a mental health professional for further assessment and treatment.

Table 1 Psychosocial assessment domains and questions [5]

<table>
<thead>
<tr>
<th>Variables (Risk Factors)</th>
<th>Suggested format for psychosocial assessment questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Lack of support</td>
<td>1. Will you be able to get practical support with your baby?</td>
</tr>
<tr>
<td>I. Lack of support</td>
<td>2. Do you have someone you are able to talk to about your feelings or worries?</td>
</tr>
<tr>
<td>II. Recent major stressors in the last 12 months.</td>
<td>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?</td>
</tr>
<tr>
<td>III. Low self-esteem (including lack of self-confidence, high anxiety and perfectionist traits)</td>
<td>4. Generally, do you consider yourself a confident person?</td>
</tr>
<tr>
<td>IV. History of anxiety, depression or other mental health problems</td>
<td>6a. Have you ever felt anxious, miserable, worried or depressed for more than a couple of weeks?</td>
</tr>
<tr>
<td>IV. History of anxiety, depression or other mental health problems</td>
<td>6b. If so, did it seriously interfere with your work and your relationships with friends and family?</td>
</tr>
<tr>
<td>V. Couple’s relationship problems or dysfunction (if applicable)</td>
<td>8. How would you describe your relationship with your partner?</td>
</tr>
<tr>
<td>V. Couple’s relationship problems or dysfunction (if applicable)</td>
<td>9a) Antenatal: What do you think your relationship will be like after the birth?</td>
</tr>
<tr>
<td>V. Couple’s relationship problems or dysfunction (if applicable)</td>
<td>b) Postnatal (in Community Health Setting): Has your relationship changed since having the baby?</td>
</tr>
<tr>
<td>VI. Adverse childhood experiences</td>
<td>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)?</td>
</tr>
<tr>
<td>VII. Domestic violence (DV) 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.</td>
<td>11. Within the last year have you been hit, slapped, or hurt in other ways by your partner or ex-partner?</td>
</tr>
<tr>
<td>VII. Domestic violence (DV) 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.</td>
<td>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)</td>
</tr>
<tr>
<td>VII. Domestic violence (DV) 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.</td>
<td>13. Are you safe here at home/to go home when you leave here?</td>
</tr>
<tr>
<td>VII. Domestic violence (DV) 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.</td>
<td>14. Has your child/children been hurt or witnessed violence?</td>
</tr>
<tr>
<td>VII. Domestic violence (DV) 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.</td>
<td>15. Who is/are your children with now?</td>
</tr>
<tr>
<td>VII. Domestic violence (DV) 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.</td>
<td>16. Are they safe?</td>
</tr>
<tr>
<td>VII. Domestic violence (DV) 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.</td>
<td>17. Are you worried about your child/children’s safety?</td>
</tr>
<tr>
<td>VII. Domestic violence (DV) 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.</td>
<td>18. Would you like assistance with this?</td>
</tr>
</tbody>
</table>

Opportunity to disclose further

19. Are there any other issues or worries you would like to mention?
12–14 weeks gestation) at their hospital booking visit and again approximately two–four weeks after birth at the time of the routine health home visit or at the six–eight week baby check in the clinic setting. In the NSW public health system, the first of these assessments is undertaken by a midwife at the hospital booking visit for pregnancy care and the second by the child and family health nurse (CFHN) who, similar to the health visitor in the United Kingdom, provide preventative health for children and families from birth to five years of age.

Studies in Australia and overseas report that most women find routine antenatal psychosocial assessment and depression screening to be acceptable [10-14] offering them an opportunity to discuss sensitive issues [11-13]. In telephone interviews with a large sample of community women, Leigh and Milgrom [14] found 100% acceptability of screening for depressive symptoms by midwives using the EPDS in pregnancy. Buist et al. [15] found a similarly high level of comfort with depression screening (85%) however, they reported that women with an EPDS ≥ 13 were more likely to find the screening process uncomfortable. Matthey et al. [16] also conducted telephone interviews before after birth to ascertain acceptability of psychosocial assessment and depression screening. They found that 65% of English-speaking women thought the psychosocial questions were acceptable, with the remainder qualifying their response indicating that they or other women may not be happy to answer certain questions such as those related to domestic violence and were uncertain as to why some questions about their childhood were relevant. One fifth (19%) of women were ambivalent or negative about the questions [16].

Conversely, concerns have been raised both nationally [17] and internationally [18,19] about the use of assessment tools particularly with vulnerable women as they may feel judged or victimized by the questioning and may deny problems such as domestic violence or their own negative childhood experiences, paradoxically placing them at greater risk of reduced access to supportive services [17-19]. Few studies have investigated the style and approach that midwives and nurses take to conducting the assessment or how women respond to the questions and make meaning of this experience.

This paper reports the findings of one part of a larger ethnographic study that sought to describe the process and the impact of psychosocial assessment and depression screening. The main focus of the study was; the approach midwives and nurses take to the assessment process and to report the midwives’, nurses’ and women’s experiences. This paper describes women’s experience of psychosocial assessment and depression screening examining the meaning they attribute to assessment and how this influences their response. The experiences of midwives and nurses have been reported separately [20].

Method
Study design
This ethnographic study was conducted in NSW, Australia between September 2010 and October 2011. Data were collected through observations of the first antenatal visit at the hospital (the booking visit) and the first visit by nurses in the home or at the clinic 6 weeks after birth. Interviews were conducted following the observations with all participating women. The opportunity to both observe the women as they interacted with Midwife or CFHN and how they felt about these questions is central to this study. Directly observing interactions, between women and midwives/CFHN assisted to understand the context of women’s experience. The subsequent interviews added depth to the observational data by asking women how they felt about being asked the assessment questions and whether this had any longer term impact on their relationship with the services. Informed written consent for participation in the study was obtained from participants. Ethics approval for the study was obtained from the Human Research Ethics Committees at both study sites and from the University of Western Sydney.

Study setting
Women were recruited from two maternity units. Both sites (A and B) provide publically funded maternity care to over 3,000 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 coordinated response/pathway was in place for women identified with potential risk factors for poor mental health. The process of assessment differed slightly at each site. The length of time allocated to conduct the visit at site A was one hour and at site B, one and a half hours; and at site B partners were able to attend for some of the visit and at site A, partners were unable to attend the booking visit. At site A, CFHN undertook the assessment at the first home visit and at Site B nurses were instructed to undertake the assessment at the six week visit when the mother came to the clinic.

Participants and recruitment
Women
Potential participants were informed about the study via information leaflets included in a package mailed to women by the hospital prior to their first appointment (booking visit). The first author was available on a regular basis in the waiting area of the antenatal clinic and approached women attending their booking visit to provide details about the study and invite them to participate. A total of 60 women were approached antenatally and 34 agreed to be observed during the booking visit with the midwife and at the first appointment with the CFHN services. They were also asked if they agreed to participate in
Women were excluded from the study if they spoke insufficient English to participate in a face-to-face interview without an interpreter. This was necessary as the study focused on the interactions between professionals and women, and the interaction may be altered if an interpreter is present. These exclusion criteria, however, did not limit participation of women from non-English speaking backgrounds.

We anticipated that 30 women (15 in site A and 15 in site B) would provide sufficient rich qualitative data across three data sets: observations, field notes and interviews from all participants. Thirty-four women were recruited to the study. Guest et al. (2006) notes that for qualitative research that aims to understand patterns and commonalities in experience and perception, 12 participants will provide sufficient data. At each of the two sites a minimum of 15 women were targeted to provide a reasonable representation of the women across both sites. The authors did not specify the background of women, nor limit the study to first time mothers, as we wanted to capture the experiences of the general population of women who are using these services and exposed to routine psychosocial assessment.

On average participants were 30 years of age, over half (20 out of 34) were born in a country other than Australia. Five of these 20 women were born in English speaking countries such as Ireland, United Kingdom and 15 women were born in non-English speaking countries such as Egypt, Laos, India and China. Eleven women spoke a language other than English. Eighteen of the 34 women were having their first baby, however, 10 of these women had previous pregnancies but had no living children due to miscarriage or termination of pregnancy. The participants were well educated with 30 of the women having tertiary qualifications and all participating women were either married or living with their partner who was the father of the baby.

Initially, all 34 women agreed to being observed at both time points, however, in the postnatal period only 20 of the 34 were observed. The remaining 14 women were not observed due to varying circumstances such as relocating out of the area where ethics approval had been obtained for observations (n = 5), withdrew from the study (n = 4), challenges involving co-ordinating visits with CFHN and the women (n = 2), did not attend their scheduled appointment (n = 2) or refused postnatal visit from the CFHN (n = 1). However, 9 out of the 14 remaining women agreed to participate in follow-up interviews even though observations were not conducted.

**Midwives and CFHN**

Sixteen midwives, two student midwives and 13 CFHNs participated in the study. The midwives and CFHNs were informed about the study through a series of researcher led discussions in staff meetings conducted at each site. Interested midwives/CFHNs completed consent forms and returned these to the researcher. Opportunity to participate in this study was offered to all midwives, working in the antenatal clinic and CFHNs who provided Universal Health Home Visit (UHHV) or clinic services, where psychosocial assessment was conducted. Student midwives were also included as participants as they were conducting psychosocial assessment and depression screening at the antenatal booking visits. The researcher then attended the antenatal clinic on days that the consenting midwives were working in order to recruit women and observe the interactions. Women who were observed antenatally and agreed to participate in the postnatal observations were matched with a consenting CFHN conducting the home visit or the 6 week visit, at which time the researcher (MR) was present to observe the interaction.

The average years of experience of the 16 midwives was five years and 12 of these midwives had worked an average of three years in the antenatal clinic. The professional experience of the CFHN ranged from less than 1 year to over 20 years. Eight CFHN had greater than five years experience. One CFHN worked on a casual basis, the remaining CFHN were employed in a permanent capacity either part or full-time.

Note: Unless specifically referring to midwives or CFHN the term midwife/CFHN refers to both midwives and CFHN.

**Data collection**

**Observations**

All data were collected by the researcher (first author MR) who is an experienced clinician in this area. The researcher (MR) observed all interactions between women and midwife/CFHN at two points in time, once antenatally and once postnatally and conducted face to face interviews. During data collection, over an 18 month period, the researcher (MR) was provided with training, support and regular supervision to ensure the quality of data collection and ‘reliability’ or consistency in recording the observations. The researcher (MR) led the development and piloted an observational tool (4D&4R) [21]. Due to the researchers’ (MR) familiarity with the tool, data was recorded in a consistent manner in all settings. Nutley et al. [22] reports that consistency amongst the usage of tools aids reliability of data sets. During supervision meetings with MR, observation tool data and field notes were reviewed by the co-researchers.

Nutley et al. [22] note that careful preparation of an observational tool can help plan how data will be recorded and can identify focal points during observations that are central to the study's objectives [23]. The development of the observational tool (4D&4R) used in
this study included (i) consideration of the study requirements in relation to the aims of the study and the study’s context; (ii) previous research in this similar context; and (iii) the authors collective and complementary cross-disciplinary knowledge and experience relevant to the study's context, content or the methodological framework. A literature review was conducted to identify aspects of communication processes that were to be observed; the means by which previous studies recorded observational data and if a tool existed that could be applied to this study [21]. A tool consistent with this study's objectives was not identified, therefore, an observation tool (4D&4R) was developed for the study [21].

The 4Ds (introDuce, Deliver, Deal and Debrief) were designed to record details about the approach taken by both midwives and nurses to the psychosocial assessment and screening. The 4Rs (React, Respond, Real experience and Reflect) were designed to observe and record details of the woman's response, including aspects such as how the woman reacted to being asked sensitive and intimate questions, what physical indicators denoted a reaction (i.e. flushed face, smiling, frowning etc.); how the woman responded, was she open and talkative in her response or did she withdraw from responding using monosyllabic responses or chose to not verbally respond at all; what was the real experience or how congruent did the woman appear (e.g. tearful at discussing traumatic event however denying that she was distressed) and was the woman observed to reflect on the questions being asked (i.e. did she ask to clarify one of the questions or did she raise her response to a previous question at some other point during the interaction) (a more detail discussed on the observation tool is reported in [21]).

Observations occurred with 15 women and seven midwives (including one student midwife) at site A and with 19 women and 11 midwives (including one student midwife) at site B. The postnatal observations of interactions between CFHN and 11 women at site A took place at the home visit conducted by the nurse two to four weeks after birth. At site B, nine women were observed in the health centre where the assessment was conducted by the nurse at six weeks after birth. This difference in time points of data collection was in response to differing implementation of the Safe Start policy [5] across the two participating sites and was unavoidable.

Field notes
Detailed field notes were used with the observational tool to document verbatim the conversation between the woman and the midwife/CFHN during psychosocial assessment and screening. Notations were also made to elaborate on the non verbal communication observed. These interactions were not audio recorded as this may have been intrusive or interfere in the interactions [24], especially where sensitive information is revealed. Briggs [25] indicates the important work that midwives and nurses do to engage women and families at the points in time when observations were conducted. The authors determined that using non-technological approaches to record observational data was less intrusive and more sensitive to these types of interactions.

Interviews
Semi-structured face-to-face interviews were conducted with 31 women in the antenatal period. These comprised 23 face-to-face interviews and eight telephone interviews within 3–4 weeks following the observation of the booking visit. Interviews were conducted at the maternity unit when the women returned for her next appointment. The telephone interviews occurred two to four weeks after the observation at a time convenient for the woman. Following birth, 29 women agreed to an interview approximately two–four weeks after the observation; 19 of these were conducted on the phone and 10 were face-to-face at a time suitable for the woman and typically in her home. These interviews comprised a series of open-ended questions to elicit information about women's experiences with the assessment process (see Table 2). The interviews took approximately 15–40 minutes and with permission all interviews were digitally recorded. Interviews were transcribed verbatim with all identifying material removed.

To ensure credibility and transferability of the findings, women in this study voluntarily agreed to participate and were recruited within a setting where assessment and screening is conducted, the antenatal clinic. Women participants were from diverse backgrounds and represent the broader population of women who attend antenatal and postnatal clinic areas, where assessment and screening is conducted. The researcher (MR) spent time in the clinic area gathering data, developing familiarity with the context and the environment. The same methods of data collection were applied to all settings and with all participants by the same researcher (MR), i.e. the use of field notes and the 4D&4R observation tool to record observational data and face to face interviews.

Table 2 Interview questions

<table>
<thead>
<tr>
<th>Questions from researcher to woman in private interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall how did you find being asked the questions related to your personal situation? (the psychosocial assessment questions)</td>
</tr>
<tr>
<td>2. Were there any questions that you felt were helpful?</td>
</tr>
<tr>
<td>3. Were there any questions you felt were uncomfortable or more difficult to answer?</td>
</tr>
<tr>
<td>4. Was there anything particular your midwife or nurse did that made you feel comfortable?</td>
</tr>
<tr>
<td>5. Do you have any thoughts about what could be done differently to help other women being asked these questions?</td>
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</table>
Data analysis
Textual data from the field notes of observations and interview transcripts were analysed thematically [26]. The observational tool (4D&4R) data were analysed descriptively using frequencies and proportions [21]. All the data including data from the observation tool (4D&4R), field notes and interviews with the women, both antenatal and postnatal, were analysed simultaneously and involved two stages of analysis. Firstly; the iterative process of thematic analysis was conducted to identify the themes and sub-themes across all textual data. Secondly; the emerging themes were examined to determine if they were consistent or not across the women’s experience at both points in time and in the context where assessment was conducted, home versus the clinic. Analysis involved multiple readings and re-readings of the observational data and listening to the recordings of interviews, this was conducted by author MR. Codes were identified that described the process of psychosocial assessment with illustrations of interaction data and the women’s response to the assessment. This was an iterative approach which involved all researchers discussing the concepts, themes and relationships during analysis. Emerging themes and the accompanying data were reviewed by the co-authors to ensure reliability of the coding. Concepts and themes were constantly compared with other themes and refined [27]. This process resulted in identification of key themes [28]. These themes are presented in phrases that, where appropriate, use the verbatim language of the participants. The descriptive data obtained from the 4D&4R data provided frequencies of women’s responses consistent with the emerging themes of women’s experience.

Results
Five key themes emerged from this analysis. The first three themes titled ‘Unexpected – a bit out of the blue,’ ‘Intrusive – very personal questions’ and ‘Uncomfortable – digging over that old ground’ describe the impact that psychosocial assessment and depression screening had on women. The lack of preparation or surprise that women experienced in relation to being asked sensitive questions that may bring up past, difficult experiences can be modified by the approach that the midwife/CFHN takes to asking the questions. This is reflected in final two themes titled: Approach: ‘sensitivity and care’ and ‘being watched’.

In addition to reporting the five major themes that emerged across the three data sets, the results reflect the longitudinal aspect of the study and aspects of the women’s journey across the two time periods when assessment occurred. Exemplars from two women are included to illustrate where women’s experience and their responses either antenatally or postnatally, may have differed. These exemplars occur in the themes sensitivity and care and uncomfortable: ‘digging over that old ground’.

Unexpected – ‘a bit out of the blue’
Analysis of the observation tool (4D&4R) and interview transcript data indicate that when the midwife/CFHN first introduced the psychosocial assessment, whether that was at the start of the visit or well into the interaction, women appeared ‘surprised’ or ‘perplexed’. This was particularly so for women at the antenatal booking visit as this was often the first time they were asked these questions, but was also observed with some women having the home visit or clinic appointment after birth. Most of the women expressed in interview that they didn’t ‘...expect ...’ the level of personal detail required to be shared at the visits and felt ‘...surprised ...’ by the personal nature and sensitivity of the questions, it came ‘a bit out of the blue’ (W9). However, they remained open to answering the questions stating at interview they ‘understood’ why the questions were being asked;

‘I think the questions that they ask are sometimes very personal, but on the other side I understand why they have logic behind the asking. They want to find out about the woman so they can help her. Sometimes there were a few questions that were very personal, like about your sexual history, that a person doesn’t like sharing the first visit.’ (W18).

Women stated they were expecting the focus to be on either the physical progress of their pregnancy or the health and development of their baby rather than on their own emotional health and well-being, ‘It seemed to be more about me than the baby’ (W11); ‘I felt it was more about me and it was more about my mental state, that sort of stuff... it was really more about how are you feeling? How are you coping?’ (W7). Almost half, (25 out of 54) of the women observed either antenatally or postnatally, demonstrated a physical reaction when asked the psychosocial assessment questions. For example, some women showed a surprised expression (raising of the eyebrows, crinkling of the forehead skin), increased eye movement, a sudden turn of the head to face the midwife, a movement, a sudden turn of the head to face the midwife/CFHN and shifting in the seat. However, after this immediate or initial reaction, two thirds of the women, (38 out of 54) responded to the questions in an open and talkative way;

(FN5) Midwife was observed to ask the woman about asking questions related to W5 psychosocial history:

M2 - ...there is also a section about you and I’ll ask you some questions about your social and emotional wellbeing is that okay?

W5 – (turn her head and looks sharply at midwife) what do you mean, what sort of questions?
M2 – they’re just some questions to see how you’re coping and feeling stuff like that

W5 – Oh okay then (sits back in chair looks more relaxed and smiling)

Some women questioned the relevance of the psychosocial assessment questions ‘She didn’t check the baby’s (fetal) heart rate it just seemed to be more about me, I’m not even sure why those other questions (psychosocial assessment questions) were relevant’ (W19).

Women were also surprised that the antenatal and postnatal visits took much longer than they expected. They attributed this length of time to be about the paperwork natal visits took much longer than they expected. They attributed this length of time to be about the paperwork.

’I was surprised it took so long. I left mum in the car waiting. I didn’t bring a bottle or a change of clothes with me or anything. I just didn’t think it would take so long’ (W7) or ‘was basically paperwork, we did lots of paperwork rather than checkups’ (W31).

Women’s level of preparedness for the psychosocial assessment questions seemed to impact on their experience. Some of the women experienced discomfort stating that antenatally they were ‘…not feeling adequately prepared…’ (W4).

W16 – I think they could have told me what they were going to ask before I even arrived for my appointment. I had no idea that was what was coming.

However, women who had a recent previous pregnancy and birth felt they were more prepared and appeared more relaxed;

’It was actually quite good. I actually quite enjoyed it. The first time you didn’t know what to expect and some of the questions that they asked I thought were a bit surprising but the second time round it was like it was nothing. It was just a conversation; they just needed to know information’ (W4).

During pregnancy and following the birth, it was evident that women expected the midwife or nurse was going to provide answers to their questions or advise them about caring for their baby, for example;

W6 – When I went for my first visit with the midwife I was like, right this is what we need to know and I just felt confident that the midwife would know exactly how to answer my questions

W1 – I knew that the nurse would come here to my home and help me to solve some of the problems with my baby.

Intrusive: very personal questions

During interviews women stated that they understood why the midwife/CFHN was asking the questions and they believed that it was ‘…important…’ and that they’…should be done’ (W16). When women had a positive experience disclosing a recent difficult personal experience, they were more likely to develop a sense of trust in the midwife that they ‘…could tell my story to anyone’ (W12). However, women also described them as ‘…very personal questions…’ and this evoked some discomfort at times and may have influenced whether they shared their story with the midwife/CFHN. Whilst most women explained that they responded honestly to the questions, stating they ‘…had nothing to hide…’ (W21), some women did say that if they were experiencing distress they may not have disclosed this to the midwife/CFHN and would simply say ‘…no…’ (W26). Due to the personal nature of the questions women reflected on whether they would discuss personal concerns with midwife/CFHN;

They ask very personal questions about your social circumstances and your relationships and things like that, which I have no problem answering but I can see how some people would if they had a problem it would be very hard to bring up like domestic violence or abuse or something like that (W26).

The observation data demonstrated support for women’s level of openness and honesty. In almost all of the observation (53 out of 54) women responded to questions and some took some time to reflect on the answer. On one occasion when a woman was tearful she continued to exclaim that she was ‘okay…no I’m alright’ (W20) and declined to discuss any concerns with the midwife/CFHN. In 5 out of the 54 observations women were offered time to reflect on the questions they had been asked. In these instances women pondered for a moment to reflect on what they had been asked ‘I guess I’ve never thought about it really but yes I guess I was a bit depressed when I was a teenager’ (W30).

There appeared to be particular questions that caused women some discomfort. Questions about domestic violence were described as ‘…strange…’ and ‘…funny…’ One woman described her discomfort as ‘…feeling guilty…’ (W11) about being asked the domestic violence questions as;

‘I kind of likened it to you know when you come through customs and even though you know you’ve got nothing you feel guilty because you now that customs people are there and they might think you’ve got something in your bags, even though you know you haven’t…it was a bit like that feeling’ (W11).
Similarly, some questions that were not deemed to be part of the psychosocial assessment were viewed as ‘personal questions’ by the women and provoked discomfort. For example, questions about previous pregnancies such as terminations or stillbirth ‘I was really hoping it wouldn’t come up…but when it does it’s like all this emotion just exploding out of me…’ (W12).

Uncomfortable: ‘digging over that old ground’

Women who did disclose a difficult current or past life event or experience in response to a question described the impact of this in varying ways. One woman described this as ‘digging over that old ground’ (W9). For others, talking about previous traumatic histories was ‘daunting’; raising fears that women may be ‘pushed back’ into reliving previous trauma. One woman stated, ‘when those words come up again (postnatal depression) you don’t want to be pushed back, like when the help is offered it’s wonderful but I felt, no I’ll be able to cope this time.’ (W12) The retelling of a distressing experience may impact in a negative way on a woman’s mood;

‘It did feel like it brought up a lot of feelings for me, like the anxiety I had when I was developing postnatal depression with my first child, it was all there, I could feel it again’ (W12).

Another woman also talked about her distress when asked to talk about a recent still birth. This was the first time she had returned to the hospital following a recent stillbirth;

it’s difficult to reply to all those questions with all my background and all my past. It makes me so stressed, when I have to go through all the questions. That’s my personal (feeling). Maybe if people have a good past they’ll enjoy it (W31).

Discussing previous trauma may not appear relevant for women at the present time of the visit ‘…it’s not really affecting me now…my main concern is getting through the pregnancy, not worrying about my past stuff.’ (W21). Women also described how they had to think carefully about how to respond to a sensitive question;

about suicidal and depressed – yeah, I was thinking actually how I put this?…because it’s actually hard to know how to say it, so you go, well, ‘how do I say this, yes I have had a plan to end my life cause I just didn’t see a way out anymore (W18).

Women who did disclose previous trauma mostly felt the nurse or midwife responded appropriately, however, they suggested that the midwife/CFHN should review previous notes so they ‘don’t have to go real deep, they can just open my file instead’ (W31) or;

‘Why don’t they take the extra time just to read over and if they have any more questions about it then they can ask. If it’s already there then why bother… it is really frustrating’ (W4).

At times, it was the response of the midwife or nurse to a woman’s disclosure that caused them the most distress. One woman (W28) talked of her experience when she disclosed a previous history of anxiety, although this had not been formally diagnosis or treated. In this case, the midwife (M16) documented this information as a history of previous mental health problems on her medical record card. The woman saw this documented and in the interview she stated;

I didn’t know that was written on the card, when I saw that there I was surprised because I don’t feel like I’m depressed or have anxiety. So I think that process made me anxious. Because now they (other midwife/ CFHN) ask me a lot about it and I am looking at it as a kind of an issue so it’s creating like a dirty mark against my name (W28).

Some women who described a negative experience of psychosocial assessment indicated that they would inform other women and discourage other women from disclosing personal information;

I don’t want her (sister) to go through the whole thing, I don’t feel the need for her to bring it up, and I don’t want her to go through her whole pregnancy having to see someone about her problems. So I told her about some of the stuff in regards to some of the questions they ask about your husband, whether or not he beats you up and I told her so she knows what will happen if she says anything (W4).

It’s funny because when you talk to girlfriends who’ve had children, you hear everyone’s different experiences and they say ‘it’s when they ask the questions it’s like, you know, it’s crazy (W25).

In some instances women’s comfort regarding disclosure of previous negative life events to the midwife or nurse differed across the two points in time (antenatal or postnatal). The exemplar in Table 3 illustrates how W17s negative experience at the antenatal psychosocial assessment influenced her decision not to use postnatal services. At the antenatal booking visit, W17 disclosed a previous experience of domestic violence which occurred more than two years previously with an
Table 3 W17s experience of psychosocial assessment across time

<table>
<thead>
<tr>
<th>Antenatal interaction with midwife</th>
<th>Antenatal interview with W17</th>
</tr>
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<tbody>
<tr>
<td><strong>Student Midwife 1 (S1)</strong> – In the last 12 months have you been hit, slapped or hurt by your partner or ex-partner?</td>
<td>Researcher [MR] – What did you think of being asked the questions?</td>
</tr>
<tr>
<td>W17 – No</td>
<td>W17 – I was surprised, I was really upset, I think they just check up the body but too much question, I’m shy</td>
</tr>
<tr>
<td>S1 – Are you frightened or scared of your husband or ex-husband?</td>
<td>W17 – My ex husband</td>
</tr>
<tr>
<td>W17 – [S1 explores] Do you have much contact with him</td>
<td>W17 – A social worker calls him and calls me</td>
</tr>
<tr>
<td>W17 – A social worker calls him and calls me</td>
<td>W17 – When you say you are scared of him is that now?</td>
</tr>
<tr>
<td>S1 – When you say you are scared of him is that now?</td>
<td>W17 – I’m not scared of him, [loudly] long time ago, for past 2 years.</td>
</tr>
<tr>
<td>FN17 – Researcher [MR] observes S1 recording a positive response to domestic violence into W17 medical records</td>
<td><strong>Postnatal interaction with researcher</strong></td>
</tr>
<tr>
<td><strong>FN17</strong> – Researcher [MR] contacted W17 via telephone to confirm postnatal observation of interaction between W17 and CFHN. W17 discussed that she had refused the routinely offered health home visit by the CFHN. W17 described the inaccurate recording of a positive response to domestic violence question by the midwife, resulting in W17 being seen by a social worker within 24 hours of delivery. W17 was asked further questions as to the nature of her relationship with her current husband.</td>
<td>W17 - They ask all those personal questions and they got it wrong... I don’t want them to come to my house; No... I don’t want to see anyone anymore</td>
</tr>
<tr>
<td></td>
<td><strong>Postnatal response to negative antenatal experience</strong></td>
</tr>
<tr>
<td><strong>FN17</strong> – Researcher [MR] observed S1 recording a positive response to domestic violence into W17 medical records</td>
<td><strong>W17</strong> –</td>
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Women’s perception of midwife/CFHN style and approach

**Approach: sensitivity and care**

It was evident in this study that how women perceived the midwife/CFHN style or approach influenced their level of comfort with the clinical encounter in general and in particular with the psychosocial assessment and depression screening. The majority of the women described the midwife/CFHN as being ‘friendly’, ‘warm’ and ‘caring’ and they believed that the professionals were ‘sensitive’ to their needs: ‘I felt she was very friendly and quite professional in the way she talked to me, I felt very relaxed.’ (W1) or ‘I found it a quite positive experience overall, I thought her approach was sensitive and caring, it was friendly’ (W24). Some women indicated that asking the questions implied a ‘...sense of caring...’ (W5) on the part of the midwife/CFHN.

Women were appreciative when the midwife or CFHN was sensitive and caring. For example, in the first interaction in Table 4, Midwife (M9) demonstrated empathy and validated the woman’s experience by acknowledging her difficult situation. Similarly when W11 disclosed that she had been experiencing emotional distress; she stated that she felt supported by the response from CFHN6 inviting her to discuss further (see Table 4).

Women also described the midwife/CFHN as helpful in terms of problem solving or assisting them to accept their pregnancy and the impact this may have on their psychosocial wellbeing. For example;

**M5 – How are you feeling about being pregnant?**

W10 – yeah ok (ambivalently), he’s (turns to look at partner) so excited, I’m kind of getting used to it

**M5 – Okay, I remember feeling like that too when I first got pregnant, what sort of things would help you to feel more comfortable about the pregnancy?**
Table 4 Examples of sensitive interactions

<table>
<thead>
<tr>
<th>Woman/Midwife interaction</th>
<th>Woman/ CFHN interaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>W9 – Have you had any major stressors in the past 12 months?</td>
<td>W11 – No I think I’ve coped fairly well, but is it normal to feel a bit emotional like during breastfeeding, it’s a bit like premenstrual… I have had a bit going on surprisingly?</td>
</tr>
<tr>
<td>W30 – Only the miscarriage (looking down into hands clasped in the woman’s lap)</td>
<td></td>
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<tr>
<td>M9 – That’s a toughy… that would have been hard, I’m sorry about that (midwife turns to look at woman and smiles gently)</td>
<td>CFHN6 – yep, yep definitely with all the hormones, but has there been anything else that has been troubling you that you’d like to talk about?</td>
</tr>
<tr>
<td>W30 – (woman looks up and turns to face the midwife) Yes it was really hard</td>
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</table>

The women who came from non-English speaking backgrounds emphasised the importance of the non verbal communication from professionals commenting for example, on the midwife/CFHN facial expressions as an indicator of friendliness ‘she always smiles and (is) very gentle’ (W14) or ‘She make me like not scared because she smile a lot, her smiling and the way she spoke was really helpful’ (W3). They also expressed an ease of communication when the midwife/CFHN ‘spoke slow to me’ (W17) and ‘explained the questions, even if I didn’t understand first time round’ (W2).

In contrast however, there were interactions where women did not receive an empathetic or sensitive response from their midwife or CFHN, as illustrated in the following interaction. For example, one woman (W4) expressed that she would prefer the midwife to refer to her medical records where she had previously disclosed trauma when asked during her first pregnancy;

M3 – so as a child were you hurt or abused in any way either physically, sexually or emotionally?
W4 – Yes
M3 – Did you want to tell me about that?
W4 – Isn’t it in my file from last time?
M3 – No… Well I haven’t read it… you can tell me about it now?
FN - Woman described her experience reluctantly

There were instances where women reported different experiences of sensitivity and care in interactions with the midwife or the nurse across the two time points (antenatal and postnatal). The exemplar in Table 5 demonstrates W12’s experience of M2’s sensitive and caring approach during her disclosure of a recent termination of pregnancy. This same woman (W12) however, was distressed by the response from the CFHN7 in the postnatal assessment where she disclosed that she felt traumatic by her caesarean birth. During interview with the researcher (MR), W12 stated that the nurse lacked sensitivity and caring.

Approach: being watched
Whilst most women were approached sensitively, some women talked about feeling as though they were being watched during the home visit by the CFHN. This was particularly reported by women for example when the CFHN commented about aspects of the home environment. This was reflected in the following interaction in the home between a nurse and a woman,

CFHN10 – You’ll need to get a gate for here at the bottom of these stairs…and what’s that cheeping sound… you’ll need a new battery for that fire alarm… do you mind if I go outside and take a look…. (walks to the backdoor) no buckets of water laying around anywhere?

W25 – We’re planning to do this (install gates at the bottom of the stairs)…. we just waiting till the baby is a bit older

CFHN10 – You need to think about this as a safety thing

In the interview following this observation, this woman stated that she felt uncomfortable with the nurse describing the interaction as ‘rude’ and ‘intrusive’.

W25 - That was a bit uncomfortable for me, when she’s checking everything… I was surprised she wanted to see how I lived… it was a bit strange, if I’d gone to the clinic she’d never have known any of these things. That was a little bit rude I thought. I preferred not to see them (CFHN) again.

Another woman described feeling ‘very upset’ and ‘guilty’ following the home visit. She described that on entry to her home; the nurse began to survey the kitchen area as though assessing the level of cleanliness and then proceeded to involve the woman’s in-laws in a discussion about breastfeeding routines. The woman was distressed by this because at the time she was experiencing some conflict about breastfeeding, she wanted to breastfeed and her parents’ in-law were discouraging her;

W11 – It was a difficult thing (breastfeeding) at the time and she (nurse) made a comment about my breastfeeding to the in-laws saying ‘if you don’t get her
This paper aimed to describe women’s experiences of assessing pregnancy and postnatal care by midwives and nurses and explored, through interviews the experiences of the same group of women during assessment before and after birth. The study found that while most women appeared to be accepting of the questions, they were taken by surprise and felt unprepared for this part of the clinical encounter with the midwife/CFHN. Overall, participants described the assessment positively believing that it demonstrated care on the part of the professional and the health service and provided them with an opportunity to talk further about any issues they may have if they wished. They also believed there was value in asking women these questions. However, women who answered positively to the psychosocial questions reported mixed feelings, with some finding the questions daunting and intrusive. One of the key factors that influenced whether the woman had a positive or negative experience at this time was the skill of the midwife or nurse and their capacity to respond sensitively to people’s emotions because a lot of people experience things differently.

Research conducted in Australia and elsewhere into the acceptability of psychosocial assessment by Matthey et al. and Rowe et al. [16,29] and depression screening by Leigh and Milgrom and Buist et al. [14,15] similarly reports women’s general acceptance of the assessment. In contrast to these previous studies based on data collected through structured surveys or telephone interviews, when women were observed in interactions with midwives and nurses in this study, some of the women were visibly uncomfortable, shifting in their seat or looked slightly flushed and others stated in interviews with a known researcher that they found some of the questions uncomfortable and did not want to ‘dig up the past’. This suggests that when this experience is explored in an in-depth way and over time a more complex picture of positive and negative experiences emerges. Participants described being unprepared and surprised by the length of time the assessment took, the number of questions and the sensitive and intrusive nature of questions. They had expected the midwife or CFHN to focus more on the health of their unborn or new baby.

Table 5 W12 experience of assessment across time

<table>
<thead>
<tr>
<th>Antenatal interaction W12 with M2</th>
<th>Antenatal interview with W12 – sensitivity and care</th>
</tr>
</thead>
<tbody>
<tr>
<td>M2 – Any past pregnancies...?</td>
<td>Researcher [MR] – what did you think of being asked the questions?</td>
</tr>
<tr>
<td>FN12 - woman observed to be distressed by these questions and cries</td>
<td></td>
</tr>
<tr>
<td>M2 – That’s alright, you’re still upset, you don’t have to talk about it</td>
<td>W12 – I knew the minute the question was asked (previous pregnancy),</td>
</tr>
<tr>
<td>W12 – I was dreading this coming up</td>
<td>I felt this from the inside just explode out of me. She [M2] was brilliant,</td>
</tr>
<tr>
<td>M2 – sorry, some of the questions are quite personal</td>
<td>I felt supported, not judged and walked away feeling I could tell my story to anyone</td>
</tr>
</tbody>
</table>

Postnatal interaction W12 with CFHN7

<table>
<thead>
<tr>
<th>CFHN7 – You have a few responses here, how have you been feeling? (note here the nurse is intending to explore the high score on the EPDS)</th>
<th>Researcher [MR] – How did you think the clinic visit went overall?</th>
</tr>
</thead>
<tbody>
<tr>
<td>W12 – There’s definitely a difference especially the way I feel physically</td>
<td>W12 – I started to get upset after that meeting. I just assumed that anyone who deals with mothers and babies is just well – they are really caring and nurturing but I didn’t feel that. I felt like it was a reflection on me, that I was bad. I felt judged</td>
</tr>
<tr>
<td>CFHN7 – Because you are feeling...?</td>
<td></td>
</tr>
<tr>
<td>W12 – Like I’ve been attacked with a machete</td>
<td></td>
</tr>
<tr>
<td>CFHN7 – [surprised] what? Because of the caesarean? I’ve had those...</td>
<td></td>
</tr>
<tr>
<td>W12 – I have found it hard to relax since</td>
<td></td>
</tr>
<tr>
<td>CFHN7 – well you’re just going to have to learn...</td>
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</table>

Feeding properly then we’ll have to blah blah blah and this just escalated things because the family got even more concerned.

The women’s experience of being watched was only reported and observed in the home environment after birth and not the clinic setting. Women who were assessed in the clinic before and after birth did not report statements about being watched.

Discussion

This paper aimed to describe women’s experience of psychosocial assessment and depression screening examining the meaning they attribute to assessment and how this influences their response. There are few studies that have examined in depth women’s experience of psychosocial assessment and depression screening and the approach taken in this study is unique. This study observed the interactions between midwives, nurses and women during psychosocial assessments and explored, through interviews the experiences of the same group of women during assessment before and after birth. The study found that while most women appeared to be accepting of the questions, they were taken by surprise and felt unprepared for this part of the clinical encounter with the midwife/CFHN. Overall, participants described the assessment positively believing that it demonstrated care on the part of the professional and the health service and provided them with an opportunity to talk further about any issues they may have if they wished. They also believed there was value in asking women these questions.
was there for them or the baby. Some of the participants in our study suggested that the real intention of the assessment was somehow hidden from them. It is noteworthy that women expressed that they may have been misled about the intention of services, as in other studies of nurses’ practice, nurses themselves report the covert strategies that they use to gain entry to conduct a home visit [25,31,32]. Shepherd [32] for example, described nurses’ acknowledgement that much of the work they do with mothers is hidden ‘behind the scales’ and that the manifest work of weighing the baby is a safe and acceptable way to gain entry to the home.

Our findings suggest that the extent and nature of the questions to be asked is not adequately explained to women prior to the visits where assessment is conducted. Participants described they were not well prepared for certain questions and they would have liked more information about the content of the visit prior to the appointment and at the start of the appointment. Specifically, women did not expect the questions about domestic violence or childhood sexual abuse and one woman compared the routine domestic violence screening to other mandatory security procedures such as going through a customs check at the airport. In a recent Australian study, Rowe et al. [29] asked women about their expectations of the health service in pregnancy and after birth. Women emphasised that they would want to know in advance the type of sensitive questions that they would be asked and they believed that the questions should only be asked by a trained professional who the woman had a relationship with [29]. Similarly, Cowley et al. [18] warn that if women are completely unprepared for this type of questioning it may influence disclosure and women may deny such problems [33].

Some women found aspects of the psychosocial assessment process intrusive such as disclosing past history of child sexual abuse, domestic violence or previous mental health concerns. Women reported discomfort particularly when they were asked to revisit past trauma or felt they were repeating their story and at times feeling they were not prepared to discuss these personal issues. These topic areas such as domestic violence and mental health issues were particularly sensitive for women. Other researchers Raymond et al. and Palmer et al. [34,35] support our findings describing the emotional distress women experienced, at times crying, when asked personal questions during assessment, including domestic violence screening. Phillips et al. [12] p.369 describes a similar finding in substance use disclosure in pregnancy when women described repeating information to health professionals as a ‘pain in the bum’. Other studies have reported women’s discomfort at being asked to open up and discuss sensitive information often not knowing the purpose and how it was to be used [19,33].

Women in this study also experienced emotional distress when responding to other questions that are part of the routine obstetric history in the antenatal booking visit and not categorised as ‘the psychosocial assessment’. Questions relating to previous pregnancies including miscarriage, termination of pregnancy or stillbirth provoked distress in some women. Studies such as Armstrong [36] have shown when women have a previous perinatal loss they experience a mixture of hope and fear of the subsequent pregnancies and most likely experience anxiety and/or guilt [37]. In response, some midwives were observed being particularly sensitive to women who reported pregnancy loss, however there were also instances where midwives and CFHN did not ‘tune in’ to women’s distress [19]. Gilbert [38] emphasises that whilst retelling the story of an event such as stillbirth or miscarriage is therapeutic, it requires trained and highly skilled clinicians who have an understanding of how to facilitate discussions with women around loss and how to respond to such disclosures [39].

Most importantly, and not surprisingly, women’s perception of the style and approach of the midwife/CFHN was the key factor that influenced her experience. Women felt more relaxed and comfortable if they perceived the midwife/CFHN was warm and empathetic. Warmth and empathy were demonstrated through verbal and non-verbal communication. Women from non-English speaking backgrounds emphasised that non-verbal communication such as smiling assisted them to feel calm and facilitated their willingness to engage with the midwife/CFHN. The quality of the communication between the woman and the midwife/CFHN influences whether the midwife or nurse will be able to form an early or beginning relationship with the woman. As Porr et al. [40] describe if a woman thinks nurses consider her needs to be a priority, and if they put effort into getting to know her, this conveys a genuine message that the nurse or midwife cares and that they are there to support the woman. Together with ensuring privacy [12], a non judgemental and empathetic approach in turn facilitates the start of a relationship [41]. If communication is poor, including in accurate recording of events, such as a positive response to domestic violence as illustrated in exemplar (Table 3), Hunter et al. [41] note this may result in sub-standard care and dissatisfaction on the part of women [41].

Most women who were observed in the home context appeared to be comfortable when being asked to provide sensitive information, including the psychosocial assessment and depression screening. However, this appears to differ from previous research. For example, in the UK-based study by Shakespeare et al. [19], women indicated that to ensure privacy and to offer adequate time and a more relaxed approach, it was more appropriate for assessment and screening to be conducted in the home environment, rather than in the baby health clinics [19]. However, some women
in this study described that when the visit took place in their home they felt as though they were being watched or monitored. Women found it intrusive when the home visit included assessment of the environment for example, when the nurse commented on the need for safety guards for the stairs. In contrast it appeared the clinic context was less intrusive than the home setting. Although most women who received a home visit appeared to be amenable to allowing the nurse into the home, some did report that they found, at times, the nurse’s approach was inappropriate, rude and or intrusive. This suggests that some women experience the home visit as a form of surveillance and as Wilson found, the idea of a nurse looking around their home can be objectionable [31]. In this situation where a woman may feel that she is being watched and monitored, she is likely to exert a level of control by stopping the service and not attending further sessions, which did occur in this study.

**Implications for practice**

These findings demonstrate that a woman’s experience of assessment may be directly impacted upon by the midwife or nurses’ approach. The development of a reciprocal trusting relationship with women and families is crucial. The fact that women allow the midwife or nurse into their homes denotes a high level of trust in these universal health services. If this trust is respected and developed by the midwife/nurse, then women are more likely to be open and trust the nurse further [42] and where there is trust women are more likely to disclose their experience [15,18,42-44]. Therefore, it is important for clinicians engaging in this process to build a positive relationship with the woman, always remaining aware that women are wary of criticism, interference or surveillance [45].

The findings related to women’s experience emphasise the need for ongoing supervision and training for midwife/CFHN focusing on skills in building good relationships with women. These skills are needed even in the first encounter, so women feel cared for and supported by the midwife/CFHN. The impact of the relationship and handling a woman’s disclosure in a sensitive manner is more likely to lead women to feel empowered and may be more likely to lead to them seeking help [46,47].

**Limitations**

There are a number of limitations to the study. First the study was conducted in only two sites and these differed in terms of length of the interview, at what point in time they occurred, and whether psychosocial assessment was conducted in structured formal ways, or more conversationally [20]. As an in depth ethnographic study, the sample size of 34 women is appropriate, however a third of these women were not available for observations following birth. Most of the women who agreed to participate were well educated with 90% holding tertiary qualifications and therefore may not adequately reflect the experiences of women who have lower levels of education. All participants (women and midwife/CFHN) were aware of the intent of the research, and it is possible that when participants’ are observed they may alter their actions and reactions to present a more ideal performance as mothers and professionals. The potential for social desirability under observation was mitigated by including follow-up interviews with women following each observation, by a researcher who was known to the women.

**Conclusions**

This study describes women’s experience of psychosocial assessment and depression screening, revealing what is helpful and the factors that lead to discomfort. Women mostly felt unprepared for the sensitive questions. There were also questions, not viewed by professionals as part of the psychosocial assessment that can cause distress. Some women who disclosed experiences such as loss of a baby or history of child sexual abuse found having to retell their story distressing and would have preferred that the midwife/CFHN referred to previous medical records to source this information. It was important for women to feel supported when they disclosed negative past experiences and personal information and be responded to with sensitivity. Women felt strongly that midwife/CFHN should collaborate around how to record the information they provide in these sensitive interviews.

**Abbreviations**


**Competing interests**

There were no competing interests in this study, financial, institutional or otherwise.

**Authors’ contributions**

MR: Carried out the data collection, participated in the data analysis and the drafting of this manuscript. VS: Assisted in the design of the study, participated in the data analysis and the drafting of this manuscript. TC: Assisted in the design of the study, participated in the data analysis and the drafting of this manuscript. LK: Carried out the data collection, participated in the data analysis and the drafting of this manuscript. All authors read and approved the final manuscript.

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8.2 Chapter conclusion

This chapter presented the postnatal data as a published paper titled, ‘Digging over that old ground’: an Australian perspective of women’s experience of psychosocial assessment and depression screening in pregnancy and following birth’. This paper described women’s experiences of being asked psychosocial assessment questions. The findings emphasise that women would benefit from being more prepared for this assessment prior to and after birth. The findings also indicated that the midwives and CFHNs conducting assessment require ongoing training and support to assist them to deliver care that is empathetic and sensitive to women who are disclosing personal information.
CHAPTER 9:
Midwives’ and child and family health nurses’ perceptions and experiences of psychosocial assessment and depression screening

9:1 Additional Findings Chapter: relevance to thesis
This chapter presents further data analysed to complement findings reported in Chapters six, seven and eight and is organised into four parts. The main focus of this chapter is the midwives’ and CFHNs’ perceptions and experiences of psychosocial assessment and depression screening. The previous four publications dealt with the specific aims but content was constrained by the limitations on length required for journal publications. The data presented in this chapter could not be included but are important. During the analysis of the data further themes were identified regarding other challenges in the implementation of assessment and screening policies. These themes further enhance the description of midwives’ and CFHN’s experiences of assessment and screening and are included here in four parts - each is discussed in turn.
Part 1: Midwives and CFHNs perceptions and experiences of psychosocial assessment and screening

- Better care for women
- I still feel uncomfortable
- Computers: just a tool or impeding the relationship with women?
- Perceptions of screening tools.

Part 2: The experience of women from different cultural backgrounds

- Lost in translation
- Interpreting the EDS/EPDS tool

Part 3: Support for psychosocial assessment and depression screening

- Learning on the job

Part 4: Partner involvement: negotiating policy requirements regarding the presence of others during assessment

- Partner exclusion
- Partner inclusion
- Women’s business
- They know anyway
9.1.1 Part 1 - Midwives and Nurses perception and experience of psychosocial assessment and screening

The published papers within this thesis in Chapter 6, 7 and 8, presented the analysis of observations of midwives’ and CFHNs’ practice and some exploration as to how CFHNs integrate assessment into their practice and the women’s experience. In this following section, the researcher reports on the midwives’ and CFHNs perceptions and experiences of psychosocial assessment. The data presented here draws on the data collected in the group discussions and interviews with midwives and CFHNs. It describes how midwives and CFHNs perceive and experience the integration of psychosocial assessment into their clinical practice. The key themes in this section highlight the value midwives and CFHNs place on the assessment process, providing better care for women, their comfort and discomfort in conducting psychosocial assessment and depression screening. The participants also talked about how the assessment process has evolved over time. However, midwives and CFHNs did express concern that the introduction of computers may threaten or impede the value of the assessment process. Midwives and CFHNs seek to balance developing and maintaining the relationship with the woman whilst documenting large amount of information in administrative databases.

Better care for women?

Midwives and CFHNs place high value on the assessment and screening process, perceiving that this practice enhances mother–child relationships and promotes mental health. CFHN’s perceive themselves as making an important contribution to the health system:

‘We’ve got the ability to assist the health service if we’re doing our job really well, our health promotion as well; this cuts down labour on chronic
Midwives and CFHNs who participated in this study indicated that they believed that undertaking psychosocial assessment and depression screening added value to their practice by enabling them to offer holistic care to women. In both discussion groups, midwives reported, that the assessment and screening process assisted them to:

‘...gain a complete picture...considering both mental health as well as associated morbidity’ (GD M1&2). The assessment enabled them to provide better care and to consider all aspects of a woman’s needs for support or intervention:

‘...it’s better care for the women, because you’ve got to look at all the facts. It’s not just the baby in the belly and the boobs... its’ everything that happens to them that impact on their pregnancy and their baby...’ GDM1

The incorporation of psychosocial assessment appears to promote a sense working within a ‘holistic’ framework for midwives and CFHNs. Some midwives implied that assessment and screening was in itself a therapeutic intervention. Participants explained that asking a woman these questions provided the opportunity for her to share information about her social and emotional health and any concerns she may have. Midwives reported from their experience that most women share or divulge a lot of information and may perceive the midwife or nurse as acting in a therapeutic role by the asking of these sensitive questions:

‘ I have had women – it was as though they had come into a counselling session because as soon as I’d asked one question, they say a lot and it was like I was a therapist’ GDM2

Midwives at site B reflected on how the assessment and screening process had evolved over time. Perceiving that the assessment and screening process has
evolved and ‘...had come a long way...’ and made a ‘...huge transition...’ (GDM2). They described their early experiences of domestic violence screening as an invisible activity that they conducted in the toilet when doing the urinalysis with the woman. Now domestic violence screening was more open and more ‘streamlined’ with the questions embedded in the psychosocial assessment. For example:

‘...about four and a half years ago we used to screen for domestic violence in the toilet... we only knew her (the woman) for about 10 minutes...now it’s much more private and much more respectful of a woman and her needs... it just seemed a little clumsier – it seems a bit more streamlined now’ GDM2

Midwives indicated that a number of strategies had helped improve and streamline the assessment process including: discussions amongst the team about how to incorporate the routine structured questions into their booking visit and they were more familiar with local support and interventions provided by other services such as mental health:

‘...we thought it would be a good idea to discuss the structure...we had input from different people who worked in perinatal mental health at the hospital and they’ve helped us to evolve our counselling skills in some degree and how we converse with them [the women] GDM2

Participants reported that over time the practice of assessment and screening has been integrated into the full assessment and is not just a specific set of questions addressed separately:

‘It’s almost incorporated in to our whole booking visit. It’s not like a section anymore’ GDM2

At site B, there had been recent changes in the way assessments were conducted, which again presented challenges for health professionals to adapt and to change in
their clinical practice. CFHNs were transitioning from administering one structured form for questions to the Safe Start questions. Here a CFHN describes how change in assessment process mandated by the new policy, had impacted on them: ‘...we’re so used to doing it a certain way...then you get thrown a new way...it’s hard to change....’ (GDCFHN1).

One of the difficulties they reported was the lack of clarity about how to integrate this change into practice. For example, when asked how they administer the psychosocial assessment questions they responded in the following way:

CFHNa ‘I hand it out’,

CFHNb ‘I wasn’t sure if I was actually meant to ask the questions?’

CFHNc ‘I thought I was meant to read the questions out; not actually give them the paper to fill out. So I think we’re still not clear on exactly how to work the new form’ (GD1).

Midwives reported that when first required to conduct the assessment they were not comfortable asking the questions and tended to do this in a directive way reading the questions from the computer screen. Midwives acknowledged that this approach to asking the questions may minimise disclosure by women. However, as they became more comfortable, midwives and CFHNs both described that they were able to subtly incorporate the questions in a conversational way and that this leads to a greater level of disclosure:

‘...when I first started asking the questions I tended to ask the questions a bit more straight forward and you don’t elicit the same responses. But now as it’s evolved it becomes more a part of the conversation.’ GDM1

Midwives also expressed that assessment and screening process offered them an opportunity to develop rapport with women. They perceived that skills such as
listening to the woman’s story and giving them enough time to discuss their experience, builds rapport and creates an environment for the woman to open up and tell her story:

‘It’s important to let them know that you are listening to them as well as understand them and how they feel....normalise their feelings and give them time to talk... normalise their feelings... develop a bit of rapport...make a few jokes...so they’re starting to feel a little bit more comfortable so they can start to open up and discuss those things’ GDM1

During field trips to the antenatal clinics midwives engaged with the researcher and often described discontent with numbers of midwives allocated to booking visits in the morning and afternoon. Midwives commented that the ratio of women booked for visits differed more at their clinics than elsewhere in other antenatal clinics:

We have a lot of histories to take in one afternoon, sometimes there’s just not enough staff and we know for a fact that at other hospitals they don’t see as many as us (FN site A)

And:

Some days you’re going from Dr’s clinic to bookings and there never seems to be enough hands on deck you know, we’ve heard at other places they just don’t get as many bookings as we do (FN site B)

The midwives reiterated that time allocated for the booking visits was sufficient at site A which was less than the time allocated at site B, ‘there’s more than enough time allocated for the history taking’ (FG_M1).

The benefits of already being familiar with families when conducting assessment and screening were described by nursing staff in group discussions.
CFHNs felt that over time they may see the same family for more than one baby and that this provides an advantage in understanding the needs of those families. They expressed a greater level of rapport with those families. The CFHNs who participated in the group discussion indicated that assessment and screening ‘...can be a lot easier...’ (GDCFHN_4) when they already have a relationship with a woman. This familiarity and relationship can facilitate and create opportunities for intervention as they have the opportunity to ‘journey’ with the women through her child rearing experiences. For example, one nurse in the group discussion described how she was the CFHN for one woman with four of her children ‘I saw her through four of her babies’ (GD2).

‘I still feel uncomfortable’

Midwives and CFHNs at both sites reported in group discussions that they felt uncomfortable asking women these questions when they meet the woman for the first time and possibly for some women it’s the first time they’ve been asked these types of questions. Participants emphasised that a high level of trust is required on the part of the woman when responding to these sensitive questions at the first meeting. They reflected on the intrusiveness of the questions and feelings about discussing topics that women may not have previously disclosed;

‘It’s a lot of trust for the first meeting. You’re asking these women all these very personal questions, and they look at you, what do you mean you’re asking me these questions? Sometimes they laugh or giggle but we’ve just met them for maybe about 10 or 15 minutes and then we get right into it.’ GDM1

And;

‘Hello, I’ve met you for five minutes; tell me your whole life story. Have you been sexually or physically abused? It’s like too invasive. It’s too much – like
she’s just told me – opened up Pandora’s box – often they’ll say I’ve never
told anyone this – that’s huge’ GDM2

Computers: just a tool or impeding the relationship with women?

Further discomfort was expressed by midwives and CFHNs in group discussion
about the challenges of integrating computers into the practice of psychosocial
assessment. The CFHNs in particular perceived that the presence of the computers
may impact on their capacity to sensitively conduct psychosocial assessment and
screening. Midwives and CFHNs also described frequent technical problems such as
‘...it blocks sometimes...’ or ‘I’m not a very quick typist’ that alter the process of
assessment making it less comfortable; ‘I’m transcribing it in front of her, there’s
discomfort in that’ GDM2. Other challenges include balancing being attentive to the
woman ‘...sometimes you need that constant eye contact...’ whilst maintaining the
documentation and paper work;

‘...You don’t want to focus so much on the paper work and the computer and
then lose what it is that the woman is trying to tell you’ GDM2

‘I felt there was too much documentation and it took it away from me being
able to talk to the woman’ GDM2

This tension that midwives have around the information gathering, reporting and
maintaining a relationship with a woman was evident during observations. Midwives
expressed frustrations related to the process and at times conveyed their discomfort
to women by apologising or describing the rationale for having to ask the questions.
Midwives referred to the questions as being ‘tedious’, ‘a fact finding mission’ and ‘a
whole load of questions’. Midwives occasionally (7 out of 34) apologised for the
sensitive nature of the questions ‘sorry, some of these questions are quite personal’
and on one occasion the midwife described herself as ‘putting the pieces together’ and the process as a ‘It’s a jigsaw...jigsaw...always a jigsaw’.

Midwives were often observed to make apologies for the amount of information they had to record, for example ‘There’s so much writing we have to do...I apologise for this’ (M5). Midwives empathised with the women ‘There are a lot of computer questions, if you need a break just let me know’ (M3). Repeated apologies were common ‘Sorry, there’s lots of things to put into the computer...Sorry; there’s just a lot of entering into the computer’ (SM2). The responsibility to enter information into the computer appeared to remain with the midwives ‘sorry, I just have to type all of this as you’re talking or else I’ll forget all of this’ (M13). Some midwives, however, did overcome this challenge by incorporating the computer into the assessment. As reported in Chapter 5, midwives at site B tended to turn the computer screen to face the woman, particularly when completing the psychosocial assessment and encouraging her to read the questions along with the midwife.

In the postnatal period, at site A computers were introduced for use in the home setting and the questions formatted on the computer included the psychosocial assessment and depression screening. I was not able to observe the CFHNs using computers as they were introduced between the time of observations and the group discussions being conducted. However, during group discussions I was able to ascertain CFHNs’ views in relation to the change. The CFHNs talked about the challenges:

I find on the computer I’m more task focused, on getting it finished, on getting it done. I would have women who would just spill (disclose)...now it’s a big wall, it’s a barrier between me and my clientele (women)” GDCFHN3.
Another added: ‘It’s taking it away from the actual time spent face to face with the client. However, it’s necessary apparently?’ (GDCFHN1). In contrast, one nurse stated:

‘I find it okay, ‘I’ve been handing the laptop to people because most people are computer savvy and they’re young, they’re really happy to get in there and learn’ GDCFHN3.

CFHNs were concerned however, that when a woman may be completing the EPDS for example on the computer, they may be able to see the actual score as it is tallied automatically ‘when they see their score adding up, they get alarmed and say.... ‘is this score okay, what does this mean about me?’ (GDCFHN4).

Perceptions of the screening tools

Midwives and CFHNs, during group discussions across both sites, raised concerns related to the use of the EDS/EPDS tool in depression screening with women. Various aspects were discussed such as whether the tool was a tool that could be used for women from diverse cultural backgrounds and its use in pregnancy.

Concerns were raised by midwives and CFHNs in group discussions about a woman’s score of zero and explained this may relate to women’s familiarity with the tool or women being unprepared to discuss their concerns with the midwife or CFHN.

Question 10 on the EDS/EPDS, relates to questions about self-harm, it appeared problematic for midwives and CFHNs in terms of the interpretation of the meaning of ‘harm’ and discomfort is experienced by clinicians when a woman scores a positive response on this question. Knowing who to refer women to and services accessibility also presented a challenged to midwives and CFHNs.
Midwives at site A felt strongly that women be encouraged to think about the EDS/EPDS questions and how they want to respond. That response required a level of understanding of the question on the part of the woman;

They (the women) should be able to answer it. And if they can’t then I don’t think we should be doing the EDS. There’s other ways of finding out how they’re feeling and how they’re coping. GDM1

At site A, midwives were concerned about the timing and the context in which the EDS is administered in the antenatal period. Midwives and CFHNs most often left the EPDS questions to the end point of the visit ‘leave it till last’ (GDM1) ‘by the time you’ve got those questions (EPDS) most of us have developed a bit of rapport’ (GDM2).

From the midwives’ experience women may be responding positively to questions because of some of the symptoms experienced in early pregnancy and a woman’s scores may not accurately represent the woman’s emotional wellbeing:

In early pregnancy you might get a bit of false representation, because some of the women come in really not feeling well at all and they’ve got a lot going on. Some of them haven’t long found out that they’re pregnant and they’re sick. They say to you, I don’t sleep because I don’t feel well. GDM1

Midwives’ interpretation of the scores played a role in how they perceived the woman’s experience. For example, midwives at site A described zero score as a trigger for them, an alarm that may indicate the woman is trying to tell them ‘what you want to hear’ and may not be ready to discuss her situation or feelings (GDM1). The midwives respected a woman’s ‘right not to disclose’ (GDM1), and believed that a zero score on EDS may indicate the woman exercising her right not to disclose. Midwives then felt they needed to provide some response to a zero score:
All you can do is give the woman the information and say, look; if there are concerns in the future we have these services. Talk to your midwife. (GDM1). Similarly, CFHNs expressed concern that if a woman scored zero on the EPDS. They felt that by the time the women were completing the EPDS postnatally, that they had most likely used the screening tool more than four times and that a level of familiarity influenced the woman’s scoring;

*I think by then they know how to work it. There was someone who scored all zeros, I said, well, when everyone scores zero’s there’s something wrong.*

GD_CFHN2

CFHNs were particularly concerned if a woman scored zero on the coping question. Referring to question six (see Appendix J), ‘*Things have been getting on top of me*’ (EPDS). CFHNs assume the women will not be coping as well as they had previously because they now have a baby;

*I say to the women, you don’t cope as well as you did before, because you now have the baby and every mum has some kind of underlying anxiety about looking after the baby.* GD_CFHN1

Midwives and CFHNs both describe question 10 on the EDS as problematic. The question relates to thoughts about harm to self (see Appendix A), midwives’ and CFHNs’ experience of women responding to this question, perceive the wording of the question as highly interpretable. Describing ‘...we (the CFHNs) think harm means harm...’ (GD_CFHN1) but alluded to how some women interpret the question to mean any harm that has happened to them such as ‘...women who think they may fall off a ladder or down the stairs...’ (GDM1) or ‘They may relate it to a child or whatever...it’s not as specific as it could be’ (GD_CFHN1). For those women who responded positively to question 10, both midwives and CFHNs felt this response
needed clarification or to be further explored to assess exactly the harm the woman is reporting.

Midwives and CFHNs also discussed the importance of enquiring on the timing of thoughts of harm as women need reminding that the EDS/EPDS relates to ‘seven days ago, not seven years’ (GDM1). A woman may not have been asked about this issue previously so she may refer to a distant point in time in her life where this has occurred.

CFHNs reflected, in group discussions, on the discomfort raised by a positive response to question 10. CFHNs experience some anxiety when a woman reports a positive response to question 10, describing physical reactions such as ‘goose-bumps’ on their skin or an increase in ‘adrenalin’ in the body, when they see a positive score. Midwives and CFHNs described modifying their practice to help them prepare for a woman’s response. Both described looking at the EPDS first to see if there is a score on question 10 so they know how to progress:

...you turn over the page to see if there’s a response to question 10 first....I always check to see if there’s anything there before adding the scores up...GD_CFHN2

If women do respond positively to question 10, many of the midwives and CFHNs anticipate a lengthy consultation process that impacts on the work that they have to get done and even missing their lunch breaks. In one group, midwives stated ‘...there goes lunch...’ (GD_CFHN2). Participants also expressed an increase in anxiety around what support was available to them to deal with this response;

There’s a lot of anxiety around asking that question and getting a response.

GDM2
However, challenges were present in ‘getting the right person’, or navigating the complex pathways of mental health consultation liaison and emergency services. Midwives and CFHNs commented on frustrations around accessing mental health care for women who responded positively to question 10:

*It’s really hard getting mental health to see them, we have to ring so many numbers and fill out all these referral forms and it’s Friday afternoon, we’re tired, the woman’s tired – we just need help* GD_CFHN3

This section has presented key findings of midwives and CFHNs perceptions and experience of psychosocial assessment. The key themes included the value placed on assessment but also explored the comfort and discomfort experienced by many. The evolution of assessment appears to be a positive experience for participants, however, midwives and CFHNs did express concern that computers may threaten or impede the value of assessment. Midwives and CFHNs place importance on developing and maintaining the relationship with women. The following section will present findings on the experience of women from different cultural backgrounds.
Part 2 – The experience of women from different cultural backgrounds and psychosocial assessment

This section discusses the assessment and screening in the context of working with women from diverse cultural backgrounds. This area of the study was also not included in the published papers. The findings reported are from observational data and interviews with the 15 women (44%) who were born in non-English speaking countries, such as India, Laos, China and Egypt. The women were asked to reflect on their experience of being asked these sensitive questions and whether they were able to comprehend the meaning of the questions. Data is also presented here from group discussions with midwives and CFHNs about the experience of working with women from diverse cultural backgrounds, the challenges of the language barrier and the use of interpreters.

Lost in Translation

Women from non-English speaking backgrounds described being asked the questions as ‘hard...it’s hard for me because of the second language’ (W17). The women described the experience as not being the ‘same’ as when being asked questions in their own language:

*She was very; very kind and I understood basically everything that she said about, but that barrier like the language, because it’s not really the same like if you’re talking in your own language* (W28)

Women also described feeling ‘shy’ when discussing these personal issues with their midwife or CFHN. For some of these women it was a new experience to be asked personal questions and the first time they had ever been asked these types of questions about social and emotional wellbeing. However, they did describe it as a positive experience and saw the health service as excellent and better than that
provided in their home countries. Four out of the 15 women from different cultural backgrounds described in interview that they had a positive experience of being asked these questions both in the antenatal and postnatal periods. They state that it denoted a sense of ‘caring’, they had not previously experienced on the part of the health professional. Some of the women described perinatal care in other countries involving a focus on the physical wellbeing. Asking the psychosocial assessment questions was conducive to a positive perception of the health care services in Australia:

*Because before I used to get to have – in Egypt or Saudi Arabia – I used to have this one for just the medical condition – they keep asking – but they not for the emotional...I haven’t experienced that before so it was some kind of relieving for me* (W24)

Some specific words used during the assessments were not fully understood by the women. The following is an example of misunderstanding between a woman and the midwife: W3 was asked if she had recently consumed any substances such as ‘marijuana, cocaine or amphetamines like speed’ (M2). The woman (W3) turned to look at the midwife and frowned not knowing how to respond. The midwife reiterates, ‘have you used any coc’ (pronounced coke) or other drugs’ (M2). The woman replies as though she understands the questions and that she can respond, her tonality increases as she smiles and nods, ‘well I have a little bit of coke each day, but just a little’ (W3). The woman is clearly referring to Coca Cola and has misunderstood the meaning of the abbreviated term for cocaine. Women were also observed to be responding to the psychosocial assessment questions with responses such as nodding or answering yes or no. There were times when the researcher felt that the woman may not be have understood and what was being asked and that they
were answering inappropriately. Women supported this in interview, describing they were not able to understand the question fully or comprehend its meaning; for example:

*It’s hard for me because it’s a second language. I answer yes and no but I don’t know about the – sometimes she ask me about the baby or something – I don’t know* (W17)

This lack of understanding of what they were being asked had detrimental effects on care for some women. In another case reported by Rollans et al (2013 - Chapter 7) a woman responded positively to a domestic violence screening question about being abused in the past 12 months. However, she was referring to violence that occurred some years ago in a previous marriage. The fact that this detail was not uncovered by the midwife resulted in an exploration of domestic violence by the hospital staff.

*Interpreting the EDS/EPDS tool*

Midwives at site A reflected on the use the tool with women from non-English speaking backgrounds and stated that ‘*Different cultures score differently*’ (GDM1). The interpretation of the questions or the meaning attributed to them by women from different cultures was not consistent with the intended meaning of the question. Midwives described having to work to overcome this challenge, explaining that this required them to reframe the questions for the women: ‘*you’ve got to sit down and really explain what the question is asking*’ (GDM1). This is also reported in Rollans et al. (2012 - Chapter six). Translations of the EPDS into other languages are available for midwives to use however midwives identify two obstacles to using a translated EPDS tool. Firstly the EPDS is not always available in the woman’s language and, secondly, some women born in non-English speaking countries are not literate in their own languages. In these instances the midwives agreed that the use of
interpreters is not beneficial as midwives believe interpreters may misinterpret the assessment questions:

We don’t encourage the interpreters to interpret the EPDS, because everyone will put their own spin on what the questions means. GDM1

Midwives and CFHNs describe the language barrier as a challenge. At times having to repeat psychosocial assessment and depression screening questions to clarify with the woman that she has understood what she is being asked:

If there’s a language barrier, sometimes they read the question and they misunderstand it; so you have to go over it again. Say, if they scored a positive on question 10 of the EPDS, you have to clarify that they understand the actual question (GD_CFHN2)

Further, developing questions to reflect meaning in the woman’s culture may not help as the following verbatim implies:

Even in the same culture words may mean different things, like let’s talk Arabic because, relationship, either engaged or not engaged, it’s the same (GD_CFHN3)

Midwives and CFHNs were observed to provide women from different cultural backgrounds with resources such as translated EDS / EPDS in efforts to assist them. In 6 out of 15 observations antenatally where this occurred, women declined the tool and preferred the midwife or CFHN to read the questions out aloud. Postnatally, the translated tool was offered on two occasions and both times it was declined. Some women further explained why this was not suitable to them; it was because they could not read their own language. This is illustrated in the following example:
SMW1 – Can you read this? (Handing the woman the translated English version of the EDS); Would you like me to get an Arabic one?

W17 – No I can’t really read Arabic

SM1 – Do you read English?

W17 – English, yeah a little bit?

MS1 – So would you prefer me to give this to you in Arabic or would you like me to read it to you?

W17 – You read it to me please.

There appeared to be mixed views from midwives and CFHNs from both sites about the use of translated tools and interpreters in the context of assessment and screening. In some instances midwives described that they do not use interpreters for assessment and screening purposes but some CFHNs had previous experience of using interpreters. However, both midwives and CFHNs commented that they were never certain that the women heard what the midwife or CFHN wanted them to hear if they used interpreters:

*We don’t encourage the interpreters to interpret the EDS, because everyone will put their own spin on what the question means. It’s more what does that question mean for the woman not the interpreter* (GD_M1)

Some CFHNs stated that interpreters were dissatisfied with the translation of the depression screening tool:

*I’ve worked with some interpreters and they say it’s (EPDS) useless* (GD_CFHN).

This section presented findings on the experience of women from diverse cultural backgrounds and the assessment and screening process. Women described
experiencing some difficulty interpreting words and comprehending the meaning of the sensitive questions. Particular question within the EDS/EPDS were problematic. There were challenges regarding the language barrier and interpreters were thought not to be appropriate in this context. The following section will explore the findings related to support provided for midwives and CFHNs conducting assessment.
Part 3 - Support for psychosocial assessment and screening

Learning on the job

CFHNs reflected on the demands of psychosocial assessment and depression screening and the skills required describing:

‘we use every skill - we should be out there using every skill we’ve ever been taught through our journey’ (GD3), ‘negotiating your way around these things (Safe Start questions and EPDS), your communication skills for example; your counselling skills that really come to the fore’ (GD2).

Midwives and CFHNs describe themselves as primarily gaining knowledge and skills in conducting assessment through: ‘learning on the job...through trial and error’ (GD2) and that formal training had not been adequately provided ‘We’ve never had any structured course, we’ve just learnt along the way’ (GDM2).

Reflection on their practice assisted them to learn what worked and what didn’t: ‘that didn’t work at all, I’m never going to ask the question that way again’ (GD2).

CFHNs identified the importance of building relationships to engage with the woman: ‘If she doesn’t relate to you... you’re gone...’ As CFHNs increasingly work with families from complex and diverse backgrounds, participants emphasised that their experiences and learning had provided them with a sense that they were ‘very diverse clinicians’ (GD3).

Overall, midwives and CFHNs concurred that ‘it had been a while’ (GDM1) since they had received any formal training related to psychosocial assessment and depression screening using the EPDS. Reference was made to previous training opportunities made available to them when assessment and screening first rolled out under a policy framework.
However, few staff could recall recent training being offered to further assist in the implementation of the policy.

*There was an excellent course that we went to a few years back, that was just fantastic...went through everything and was awesome...but they haven’t run that for many years* (GDM1)

Most midwives agreed that they preferred to debrief immediately and informally with one another when dealing with a challenging clinical scenario: ‘we bounce it off each other....if something happens at lunchtime it’s pretty much nutted out’ (GDM1). Others noted that supervision had been available to them but it was difficult to get to and described inconsistency with supervisors:

*We used to have it here (in the antenatal clinic). A different person facilitating, but unless it happened very recently, a lot of people just forget about it* (GDM1).

*It’s better immediately...because there’s so many stories...you get some really big story and then you forget about it* (GDM2).

This section has explored midwives and CFHNs perceptions and experiences of education and training. Most clinicians discussed that they had evolved their practice over time mainly from observing others and what worked and what they would improve. Although training was offered few were able to share they had undertaken this at the time. The following section presents findings on how midwives and CFHNs negotiate policy requirement with regard to partners being present or others.
Part 4 - Partner Involvement: negotiating policy requirements regarding the presence of others during assessment

It is important to consider the ways in which the midwives and CFHNs negotiate the role of partners in the booking visit and in the postnatal visits. How partners or others that may be in attendance are ‘managed’ at each site, before and after birth, appears to reflect how the policy around psychosocial assessment and the asking of these sensitive questions is being negotiated in clinical practice. In observing the process of psychosocial assessment and depression screening conducted by midwives and CFHNs the way that partners are dealt with appears to impact on the interaction, both between the woman and the clinician conducting the assessment, and the partner or other person in attendance with the woman. Therefore, how partners are ‘managed’ or dealt with is included in these additional findings to provide a greater perspective of the challenges presented to midwives and CFHNs during the psychosocial assessment process and the impact that the assessment process has on midwives, CFHNs and the women. The approach to reporting these findings includes key themes such as administrative requirements, attempts at inclusion, women’s business – to be present or not and they know anyway – partner perception.

Partner exclusion

The way in which midwives and CFHNs approach male partners and others who attend the visit varies at each site and depends on the local policy and protocol relating to the attendance of partners. Difficulties or challenges arise when dealing with the local protocols. At site A if others arrive at the clinic with the woman, the midwife has to explain why they are not able to be present. At site B midwives negotiate an appropriate time for the partner to leave the booking visit. Midwives and CFHNs adopt various strategies to negotiate these policy requirements. Strategies
included reading verbatim the explanations provided in local protocols or making light of the situation through the use of humour.

At site A three of the 15 women were accompanied by their partners or another person to the antenatal clinic. On each occasion, the midwife was observed explaining to the woman and her partner/others that they were not permitted to accompany the woman for the booking visit and they were requested to wait in the waiting room. In two of the three appointments, the person accompanying the woman acquiesced and returned to the waiting room without saying anything. However, on one occasion the male partner indicated that he was distressed by this, stating in an irritated/angry voice, ‘*she has nothing to hide*’ P17. The woman also appeared displeased with the request (perplexed facial gesture, crinkling of the forehead and decreased eye contact) but tried to console the partner by saying ‘*it’s okay just wait we won’t be long*’ (W17).

At site B, partners were present in 10 of the 19 antenatal observations and in one instance; the woman’s mother attended but was treated by the midwife in the same way as a partner. Midwives appear to have the process of ‘dealing with’ the policy requirements streamlined. At the start of both the antenatal and postnatal visits the midwife/CFHN would inform the partner/mother that they would be asked to leave the room for part of the appointment, for example:

M5 - _There’s a whole load of questions, about your physical health and there’s a section on your emotions and social supports and we’ll ask you (looks to partner) to leave the room during that section._

‘We’re going to run through a whole set of questions and at one point (turning to face the partner) _just ask you to leave the room for a 5 minute chat_’ SM2
At times, midwives made reference to what would be asked during the partners’ absence. The following is an example of this explanation;

‘So the following questions are a little bit sensitive so we get all family/partners out, we only do this questionnaire with the woman, so I’ll just get you to wait outside’ M14

‘It’s been lovely meeting you, I’m going to get you to wait in the waiting room for the last 5 minutes or so, just while we ask you (turns to woman) a few more questions or so, those personal questions we just do that as a routine thing’ M9

Midwives on occasion use humour to approach this issue. For example, on one occasion, the woman’s partner explained that he was feeling ‘guilty’ that he would have to leave the appointment early and the midwife responded with, ‘Don’t worry, we’re going to kick you out at some point anyway’ SM2.

Partial inclusion

Where the partner was present, midwives and CFHNs were observed to use a range of simple strategies to include partners in the antenatal or postnatal visit. For example; they greet the partner by name, demonstrate sensitivity to the concerns of the woman and the partner and create opportunities to discuss their feelings about becoming parents. Partners were observed to interact actively during the booking visit, seeking advice or guidance from the midwives, demonstrating concern for their female partner and the unborn baby and wanting to be involved in the process, for example, one father-to-be stated ‘So the echo test that you mentioned... there’s no need for that, the amnio covers everything?’ P30.

In the postnatal clinic settings, the CFHN requested a partner to leave the room during the psychosocial assessment. Similar to the midwives, CFHNs use
different strategies to manage this. On two occasions for example, the CFHN offered the male partner the opportunity to complete the EPDS himself. This occurred with two different CFHNS and may have represented an attempt at partially including the partner in the process.

One CFHN introduced the EPDS to the partner in the following way:

Would you like to complete one of these, it’s a depression scale; you can do one of those while you’re out there (CFHN7)

In this instance, the woman (W12) then went on to describe to the CFHN (CFHN7) how her partner was tearful when leaving home to go to work as he did not want to leave the baby. The CFHN7 then asked the partner to return to the room following the woman’s psychosocial assessment at which point he handed the completed EPDS to the nurse. The nurse calculated the score and noticed it was higher than the woman’s. The CFHN then attempted to explain the difference in the scores as seen in the quote below, however, no further resources or supports were offered:

Now that’s fine, because you’re very supported (looks at the woman) was only 3 and you (looks at the partner) taking the stress more, more stress on you probably, (referring to the partner) 8 but they (the EPDS score) are still fine CFHN7

On one other occasion when a woman’s partner (P21) was asked to complete the EPDS, the nurse (CFHN13) simply took the completed paper-based EPDS from the man, reviewed it herself and placed the copy of the EPDS in the woman’s file with no further conversation or feedback to man or the woman (W21).

Women’s business

During observations of psychosocial assessment process, it was evident that the request by a midwife/CFHN for the partner to leave impacts negatively at times on
the woman and her partner. In the following interaction the partner of one woman (W14) was asked by the midwife (M7) to complete some paper work. When he returned to the interview room with the completed forms the midwife had commenced asking the psychosocial assessment questions and refused him entry into the room without explanation. The partner looked concerned about this as his wife spoke limited English and he had been assisting with interpretation. As instructed, he waited in the waiting room; however, this was a long wait. The assessment took approximately 40 minutes and the midwife did not prepare the partner for this or provide any further explanation to the partner. The partner approached the receptionist of the antenatal clinic, who telephoned the midwife. On receiving this call, the midwife responded to the receptionist in an angry voice stating ‘tell him to wait’ (M7).

Furthermore, the language used to describe what was to happen while the partner was out of the room may also impact on the woman or partner negatively. On one occasion, CFHN7 explained to a partner when requesting him to leave the room, ‘If she’s complicated I’ll be more than a few minutes’ to which the partner replied; ‘I’ll see you in an hour then’. The CFHN and the partner then laughed loudly together. The woman looked uncomfortable at this comment (puzzled expression on her face, crinkled forehead and slouching in her chair). In another situation the partner was asked to leave the clinic room because ‘we’re going to talk about you (partner) now’ (M9).

During one-to-one interviews with women antenatally, nine out of the 34 discussed the issue of their partners being present and the women had differing views as to whether they should be present or not. The majority of women (6 out of 9) agreed that it was better that their partners not be present, describing the assessment
process as ‘women’s business’ and that they felt more comfortable and could speak more freely when their partners had left the room. However, some did suggest that it would be useful to also ask the partner how he is feeling, in other words to undertake a psychosocial assessment with the partner:

'It was good that my partner was not there because I was able to talk very frankly but on the other side he should also be interviewed at some point, how does he feel so they can together calculate and plan for both of us' (W18)

At site A, where partners are excluded from the booking visit, two women discussed during interview that they would have preferred their partners to be present for some of the booking visit and one woman would have liked him to be present during the psychosocial assessment. The women indicated that if their partners were there it would have provided an opportunity for the partners to engage more with the pregnancy and gain a greater understanding of what was occurring: ‘he’s found it hard to identify with it...he would have understood a little bit more about what we’re about to do’ (W9). In addition, their partners were perceived by these two women as their main support particularly if they felt ‘shy, alone and overwhelmed. A woman of Arabic background who disclosed one negative life experience relating to domestic violence in a previous relationship 5 years prior, stated:

‘I would like him to be there for support...very hard for me to talk about those things and he understands he could have helped me’ (W17).

This woman (W17) also described following her disclosure that she was quite distressed and her husband was the person who provided support for her following the visit.

On two occasions, when the midwife was collecting information from the woman about her general health and reproductive history, the partner was also
included by the midwife in questions relating to family history of mental illness. One partner disclosed a significant previous and current mental health problem. In this instance the midwife made an effort to ask further about this history and offer support:

_M5 – Any mental health history in the family? (Looks to both the partner and the woman)_

_P10 – I suffered from depression_

_M5 – Yes, can you tell me a little bit about that, was it a long period of time in your life?_

_P10 – About 6 years in my early twenties._

_M5 – It was depression that they diagnosed?_

_P10 – They labelled it schizophrenia, paranoid schizophrenia, I was just hanging out with the wrong crow._

_M5 – What sort of follow up do you have now?_

_P10 – I have a psychiatrist and I take my medication (antipsychotics) everyday._

In the interview following the ante natal appointment, this woman (W10) described feeling uncomfortable and vulnerable when her partner had to disclose this history:

_‘I was a bit annoyed at the time, he didn’t have to go into everything...she (the midwife) said we need to monitor that in respect of someone, I think comes to visit to check the psychological aspects of the child or after the baby’s born’_ (W10).
This woman went on to express concern that she and her family would be monitored by a range of health professionals and that their baby may be labelled as being ‘at risk’:

‘I know they’re going to think now that my baby is going to have it but I don’t believe in the genetic thing’ (W10).

They know any way

It is more than likely that when partners were asked to leave the room and were waiting for the midwife to complete the assessment, that they would be thinking about or considering what was being discussed between the woman and the midwife/CFHN. In most of the instances (six out of nine) where a partner accompanied a woman to the antenatal appointment and was asked to leave, the partners told the women following the visit that they knew what was being asked. Some women in interview described their partners as intuitive:

‘he is very intuitive, he knew exactly what was being asked’ (W12) or ‘he said oh I know what they were asking you – probably it was that I hit you or something’ (W28).

In one interview, a woman described what had occurred after the antenatal appointment, explaining ‘he asked me when I came out what I was asked?’ (W11). The woman stated that she responded honestly to her partner and explained that they had discussed domestic violence screening and then laughed about it together:

Oh we were just talking about if I’d had any problems with him and that sort of thing. So he just – cracks a lot of jokes about me being asked about whether he beats me up. But he knows it wasn’t that anyone thought anything was happening. It’s just part of the routine of the appointment (W11).
This section presented findings regarding how midwives and CFHNs negotiated the policy requirements assessment of the women without partners present. How they navigated this challenging terrain. Including women’s perceptions of partner involvement and exclusion; women believing it is women’s business and others suggesting it may be helpful and supportive to have partners present.

9:2 Chapter conclusion

This chapter presents the analysis of data not included in the four publications that form part of this thesis. The focus of this chapter is on the midwives’ and CFHNs’ perceptions and experiences of psychosocial assessment and depression screening. These data are considered important as they explore other challenges in the implementation of assessment and screening policy requirements and enhance the description of midwives’ and CFHNs’ experiences of assessment and screening. The following chapter synthesises the findings reported across four publications, including the further findings of this chapter and discusses them with reference to existing literature, new knowledge and implications for midwifery and nursing practice, education and policy development.
CHAPTER 10:  
Discussion 

10.1 Introduction 
In this Chapter I will synthesise the findings from Chapters six, seven & eight and provide further discussion on the findings presented in Chapter nine. This study aimed to examine and understand the meanings midwives, CFHNs and women make of the process of psychosocial assessment and depression screening undertaken during pregnancy and early parenting. Further, the study aimed to achieve the following objectives: 

- Describe the approaches (actions and interactions) that midwives and CFHNs take to psychosocial assessment and depression screening. 
- Examine midwives’ and CFHNs’ experiences and perceptions of the assessment process. 
- Explore women’s experiences of being asked the psychosocial assessment questions - and how this influences women’s responses. 
- Identify how the dynamics of these interactions facilitate or hinder the assessment and screening process and the potential for women to engage in ongoing support services or interventions. 

To achieve these objectives data was collected from observations of the interactions between midwives, CFHNs and women during the assessment process followed by face-to-face interviews with both the clinicians and the women. Discussion groups were also conducted to understand the midwives’ and CFHNs’ experiences and perceptions of the assessment process. A total of 34 women were observed in the antenatal clinic before birth and of those 20 were also observed after
birth. Of the 34 women observed antenatally, 31 participated in an interview with me and 29 agreed to interview postnatally. In addition, the 18 midwives and 13 CFHNs participating in this study, allowed me to observe their assessments of women, as well as to participate in interviews. The focus of the interviews was to determine factors that facilitate or hinder the assessment process. Finally, 38 midwives and 80 CFHNs took part in discussion groups to reflect on the evolution of the assessment process and to identify what was needed to further support this practice. This is the first known Australian ethnographic study to investigate the structured psychosocial assessment process both antenatally and postnatally, following the same group of women over time, using a combination of methods such as observations, interviews and group discussions. The study design also provided the opportunity to observe the health professionals, midwives and CFHNs, responsible for undertaking psychosocial assessment as recommended by NSW state policy (Health, 2009). This research has important implications for policy makers considering the national rollout of psychosocial assessment in Australia.

The following issues are addressed in this discussion; the value of an ethnographic approach to the research process; an overview of the study’s findings; and exploring the tensions experienced by midwives and CFHNs conducting psychosocial assessment. In this study midwives and CFHNs emphasised the importance of adopting a relationship based approach that required specialised skills be developed. How women responded to the approach of the midwife or CFHN and their experience. Midwives and CFHNs are conducting assessment as recommended by policy, however, the implementation of the Safe Start policy into practice appeared varied between sites. This study’s findings have implications for practice with regard to support and training of clinicians, along with other implications such
as the preparation of women and, appropriate responses to screening results and referral pathways. This study’s limitations, recommendations for future research and conclusion will complete this thesis.

10.2 Synthesis of findings

10.2.1 The value of an ethnographic approach to the research process

Approaching this research using an ethnographic approach allowed me to immerse myself in the clinic and home environments of women, where midwives and CFHNs practice and conduct routine psychosocial assessment and depression screening. As I became familiar with the clinical environments and with the process, I was able to closely observe the approaches that midwives and CFHNs took to the assessment process and the women’s responses. The ethnographic approach also allows for inclusion of the social and political climate currently surrounding the SFE policy implementation in NSW LHD. I could consider the context in which the assessments are conducted, i.e. home versus the clinic; the context of the release of the SFE policy and how practices varied across disciplines and between sites. Ethnography allowed me to tell the story of the process and impact of psychosocial assessment from within the field where assessment and screening occurs. Midwives, CFHNs and women allowed me to observe them and share in their experiences of the assessment and screening process. I was able to observe for factors that appear to facilitate or inhibit the process of assessment for midwives, CFHNs and women. Face to face interviews, with those midwives and CFHNs who were directly observed, allowed them to reflect on how they felt the assessments had gone and what may facilitate or hinder the process. Interviews with the women added depth to describing each interaction and the impact of the approach or style of
midwives and CFHNs on the women’s experiences. Discussion groups with midwives and CFHNs encouraged reflection on the evolutionary aspects of psychosocial assessment, since its inception to the present and how midwives and CFHNs perceive their professional needs to continue to conduct these assessments routinely with all women.

10.2.2 Study findings: an overview

Analysis of the antenatal and postnatal observational data, including field notes and interview transcripts, with midwives and CFHNs, identified the following key themes and issues in psychosocial assessment and screening process, as detailed in Chapters six and seven (Rollans, 2012, Rollans, 2013b). In Chapter six, publication two, findings were presented in chronological order to describe the process and approach that midwives take to the phases of assessment such as: ‘The greeting’, ‘Delivery’ and midwives’ ‘response’ to women’s positive answers. The midwives who participated in this study appeared to place importance on the engagement process and forming a relationship with a woman from the commencement of the booking visit.

The key finding in the antenatal process of assessment is reflected in the title of publication two, 'We just ask some questions', taken verbatim from midwives who were conducting assessment. Midwives used a range of strategies, including introducing the questions, to help the women and themselves feel more comfortable asking them. It was observed that midwives developed their own style and approach to setting up the interaction, modifying the questions and incorporating them into the booking visit. Modifications are made to the wording and phrasing of the questions. This may be a response to midwives attempting to create more comfort for
themselves and for the women. Mostly midwives were observed to respond to women’s disclosure of previous negative life events with empathy.

Similarly, the postnatal observational data presented in Chapter seven, publication three, (Rollans, 2013b), demonstrates that the CFHNs, as with midwives, place emphasis on the ‘Engagement: getting that first bit right’ and then later ‘creating comfort’ by referring to the assessment as ‘Doing some paperwork’ rather than conducting an assessment. The CFHNs who participated in this study were observed to demonstrate a range of skills, such as how a woman engaged with her baby as an indicator of how well the woman was coping. CFHNs not only rely on the delivery of structured assessment questions but utilise information sourced in ‘other ways’ to determine care required by the women. This is described in the key theme ‘Psychosocial assessment: doing it another way’ (Chapter seven, Rollans, 2013b).

‘Doing it another way’ was evident in the differences observed between sites in terms of the frequency of psychosocial assessment conducted using a structured tool. Most CFHNs in this study preferred to use other skills to assess women’s social and emotional needs and felt confident they could complete the structured tool without asking the questions directly.

Women’s experiences and how they respond to the assessment process were explored using transcripts of interviews and findings from the data observing women (Chapter eight, Rollans, 2013c). Some of the women were observed and interviewed at both times where assessment was conducted, before birth at the antenatal booking visit and then after birth at the first home visit, UHHV in the first two weeks or the six-eight week baby check. These data were analysed together, across both points in time. This approach to analysis was used to determine women’s overall perceptions of the psychosocial assessment process but also to determine whether there were
changes in perspectives or experiences of assessment across the perinatal journey.

During analysis I sought to identify key aspects of the midwives’ and CFHNS’ approaches that facilitate or hinder the assessment process. The key themes firstly described the women’s experiences of being asked the psychosocial assessment questions and how the women perceive the midwife’s or CFHNS approach and style. Women describe being asked the psychosocial assessment questions as ‘Unexpected – a bit out of the blue’ and ‘Intrusive – very personal questions’. In responding to the questions and disclosing sensitive information, women felt ‘Uncomfortable’ and refer to this experience as not expecting to be ‘digging over that old ground’.

Women’s experiences of disclosing previous negative life events appear to be influenced by the approach taken by the midwife and nurse. Women describe a negative experience following disclosure when the approach of the midwife or nurse was less sensitive; women who were visited in the home felt some discomfort and describe feeling as though they were ‘being watched’. Those women who disclosed previous negative life events were distressed by the experience and referred to it as ‘digging over that old ground’. Women’s partners are excluded from the assessment process; however they are the main support for the women who experienced distress.

In Chapter nine, I presented findings from the analysis of discussion groups and interview data that reflect on midwives’ and CFHNS’ perceptions. Midwives and CFHNS both perceive that psychosocial assessment provides ‘better care for women’; however the process of conducting assessment presents them with challenges. Challenging situations include: asking the assessment questions of women from diverse cultural backgrounds; negotiating policy requirements regarding the presence of partners or others; using the EDS/EPDS and fear of a
positive response on questions 10 and how midwives and CFHNs continue to learn on the job.

Considering the overall presentation of findings and discussion of various aspects of these findings, it becomes evident that the midwives and CFHNs in this study experienced tensions in conducting assessment and screening. Midwives and CFHNs value a flexible approach to assessment whilst incorporating structured tools. Midwives and CFHNs in this study also prefer and emphasise a relationship based approach to women when conducting assessment. The implementation of SFE policy recommendations regarding assessment and screening process may provide some explanation for the differences observed and the tensions experienced in conducting assessment.

10.2.3 Tensions experienced conducting psychosocial assessment

Observation data, the interviews and discussion groups indicated that midwives and CFHNs feel conflict or experience tension relating to psychosocial assessment but that both groups believed that asking these questions was important. However, midwives and CFHNs in this study describe discomfort asking sensitive questions about child abuse and domestic violence for example, particularly at their first meeting with a woman. Although midwives and CFHNs in this study perceive that psychosocial assessment and depression screening enhances their practice.

This finding is supported by previous studies ((Marron and Maginis, 2009, Mollart et al., 2009, Gutmanis et al., 2007, Sanders, 2006) that midwives and CFHNs experience difficulty finding appropriate ways to ask the questions. McCosker-Howard et al. (2005) also describe embarrassment and discomfort that midwives feel when asking questions relating to domestic violence. However, midwives and
CFHNs in this study did express that familiarity with the assessment questions assists them to feel more comfortable in asking them.

Mollart, Newing and Fourer (2009) found that midwives were overwhelmed by the amount of sexual abuse disclosed during screening process. Midwives and CFHNs in this study describe experiencing anxiety when anticipating or receiving a positive response to one of the psychosocial assessment questions or the depression screening tool (EDS/EPDS). Some experience fear about ‘seeing’ a positive answer to questions 10 relating to self-harm on the EDS/EPDS, to the point where they even describe turning the page over to see if there is a response before reviewing the rest of the questions. A positive response to question 10 evoked fear that a woman may harm herself. Midwives and CFHNs were also concerned that it took time clarifying the issues. Sanders (2006) also found that clinicians may fear a positive response to sensitive questions and this may increase discomfort for clinicians who are required to ask the questions. Mollart, Newing & Fourer reported midwives high level of stress after dealing with positive responses; they had difficulty leaving their work in the work place, often thinking about unsafe women on the their way home. CFHNs in this study, during group discussion, went as far as to say that they found the assessment process burdensome and questioned whether they really wanted to know about women’s risk factors.

In contrast to the research on risk factors, there is less research around protective factors and impact on maternal and infant outcomes. Identified potential protective factors are: appropriate social support, good physical and mental health, adequate self-esteem, adequate social and economic circumstances, an uncomplicated delivery, and a healthy infant and maternal attachment state of mind (Priest et al. 2005). Barclay and Kent (1998) argue that the EDS screening tool
places greater emphasis on the medicalisation of what may be, for some women, an adjustment to a new lifestyle with a newborn. A view shared by Matthey and Ross-Hamid (2011) who suggest that the practice of routine depression screening may be potentially ‘over pathologising motherhood’. Midwives and CFHNs psychosocial assessment in this context overemphasises or focuses strongly on risk to the exclusion of protective factors, such as a woman’s strengths and her available supports. From these professionals’ perspective this structured process may be impacting on their ability to build rapport and a relationship a woman. This is discussed further in the next sections.

10.2.4 Structure and flexibility

‘Structure’ in relation to psychosocial assessment in the context of this study refers the structured format of the assessment tool where the questions are embedded in a computer data base or where questions are presented to a woman as a list to be completed on a sheet of paper. Midwives and CFHNs have mixed views about the introduction of structured tools for psychosocial assessment; their opinions and practices vary about assessment questions incorporated into practice. Structured tools are welcomed by some midwives, including the move to embed formatted psychosocial assessment questions within their administrative data base. However, some of the midwives observed conducting assessments were students or had been practising less than five years, so structured delivery of questions may have always been part of their practice.

Midwives describe that having a structured process and time allocated for psychosocial assessment as a positive aspect of their practice, helping them to feel confident to conduct the assessments. They welcomed the introduction of structured psychosocial assessment tools, perceiving them to be part of an ‘evolutionary’
process. Reflecting on their previous assessment practices, stating this has begun by conducting domestic violence screening in bathrooms whilst performing urinalysis with the women. The structured tools allow midwives to feel they have ‘evolved’, from conducting screening in a more covert way in the bathroom, to the more comfortable and overt way in the clinic setting. CFHNs, on the other hand, particularly at site 1, appear to resist the structured format and explain that they do not need a structured format to complete a psychosocial assessment; they believe that they are able to do it in other ways. Cowley and Houston (2003) found that, in an attempt to avoid any discomfort, health visitors are less likely to ask women psychosocial assessment questions in the structured format at the first time they meet the woman.

A ‘flexible’ approach to assessment process was observed in this study on occasions where midwives or CFHNs did not use a structured tool but rather asked questions in their own way to assess a woman’s psychosocial situation. There were also instances where midwives and CFHNs used a tool but incorporated it into their practice in a flexible way, such as modifying the order or wording of the psychosocial questions. However, modification of questions may be problematic as was discovered in this study where midwives and CFHNs would reframe questions based on their interpretation of the meaning. CFHNs were observed to be ‘doing IT (assessment) in other ways’. For example, CFHNs appear to prioritise how the woman was feeling based on how she interacted with the baby. The study’s finding is reinforced by Appleton and Cowley (2008) that health visitors’ assessments involve the whole situation, requiring complex and skilled process that include the gathering of assessment data from a variety of sources.
Midwives and CFHNs indicate that they need to build rapport and level of relationship with women in order to be able to ask the questions in the first place. Taking a more flexible approach enables them to be more in tune with the woman; from their perspective allows them to continue to build the relationship. However, adopting a flexible approach to assessment did not necessarily ease the tensions that the midwife or CFHN felt undertaking the assessment. In attempts to minimise discomfort, midwives and CFHNs adopt various approaches to asking sensitive questions, such as using humour and/or modifying the questions and minimising the assessment. As described by Clancy (2012), nurses may adopt a joking, jovial and informal tone to the approach when discussing sensitive topics.

There is limited literature comparing structured and flexible approaches to assessment, however, Marron and Maginis (2009) found that CFHNs like having a structured format and assessment framework to ask these questions. The structure provides a framework that they can work into more flexible, relationship based ways (Marron and Maginis).

Following birth, however, it appears that less attention is paid to the structured psychosocial assessment by CFHNs, particularly in the context of a home visit. Whether structured assessment tools are required appears to still be an issue for debate. Cowley and Houston (2003) found that some clinicians still advocate for a more flexible approach that incorporates the clinical judgement of the health professionals to determine the level of intervention or support that is required. Some of the midwives and CFHNs in this study feel that the structured format of the questions is insensitive and lacks appropriate timing. In an attempt to avoid any discomfort health professionals are less likely to ask women these questions in the required format the first time they meet the woman (Cowley and Houston). Cowley
and Houston (2003) rejected a structured format, believing that it does not allow for the flexibility required to elicit sensitive information and suggest that these issues should be uncovered by the health professional during their ongoing contact with a woman, as was echoed by Kardamanidis et al. (2009). However, this study found that in NSW most CFHNs and many midwives will not see the same woman again and so the emphasis in the policy is on collecting the information at one of the first appointments, before and following birth, so women are not overlooked.

In this study midwives were observed modifying questions to ask them in different sequences to suit their individual styles and the needs of the women. In adopting a flexible relationship-based approach (Davis, 2010), situations can be modified to meet a woman's or family's needs. This flexible, relationship based approach, used by midwives and CFHNs is characterised by sensitivity and care influenced women’s experience, in interviews women felt more positive following disclosure of a negative life event.

10.2.5 Adopting a relationship based approach

Both midwives and CFHNs appeared to prioritise establishing relationships with the women. The interactions between midwives, CFHNs and women at the time of assessment are multilayered and complex. The midwives and CFHNs work diligently to negotiate the clinical encounter in order to effectively undertake psychosocial assessment. Both at the start of the encounter and throughout the assessment most midwives and CFHNs worked in a sensitive and caring way to ensure that women were comfortable and that they could build a relationship. This was demonstrated in the initial phase of engagement were observed to convey sensitivity and caring, as observed through non-verbal and verbal communication, such as smiling at the woman and negotiating with her as to how best to commence the visit.
In this study women responded positively to facial gestures and expressions. A smile from clinicians helped them feel more at ease and comfortable. The projection of optimism at the initial stage of relationship development was observed in public health nurses in Canada in their interactions with women (Porr, 2011). The midwives and nurses in this study also appear to display happy and friendly dispositions at the onset, which appear to have a positive impact on the woman conveying a sense of the midwife or CFHN being easy going and that consequently the rest of the assessment may go well. This also assists in establishing an initial rapport with the women (Porr). A display of sensitivity at the commencement of the visit establishes a sense of attunement to the woman, which Oberle and Tenove (2000) describe as, a discrete balance that the nurse develops in tuning into and understanding women’s needs by being sensitive in their approach. Over time this sensitivity to women assists the nurses to attune to their strengths, capacities and vulnerability or potential risk (Oberle and Tenove).

Researchers, Shakespeare (2003) and Armstrong and Small (2007) both suggest that women prefer to talk with a professional about their concerns or worries rather than complete a questionnaire. This was echoed by Kardamanidis et al. (2008) who found that in interviews with CFHNs, who were providing sustained nurse home visiting, that women were more likely to disclose sensitive information when time was taken to build a trusting relationship than if simply asked a series of prescribed questions. Similarly CFHNs also appear to prefer to talk with women and to make assessments about their social and emotional well-being by using clinical judgement which is informed by gathering information in a range of ways, one of which might be a screening tool. CFHNs in this study chose to adopt a more relational approach to assessment where they observe for social cues, demonstrating a non-judgemental
approach to hearing women’s stories and displaying empathy. Browne (2009) report a similar finding in their study where nurses in their study described that observing the non-verbal and verbal cues given by women assists them to observe for women’s responses that may indicate distress, such as tearfulness, little or no verbal contact etc. CFHNs and midwives in this study recognise that it is on the basis of a relationship that they are able to effectively assess the needs of women.

10.2.6 Skills required in undertaking a flexible approach to psychosocial assessment

In this study midwives and CFHNs describe psychosocial assessment and depression screening as difficult work. This perspective is shared internationally; other researchers (Browne, 2009, Briggs, 2006, Kemp et al., 2006) also indicate that this is not easy work. Briggs (2006) describes that the assessment of social, emotional and mental health needs as multidimensional, requiring specific skills in understanding and interpreting women’s responses and being able to attend to the emotional needs of women. Authors Browne, Briggs, Kemp et al. have identified psychosocial assessment as requiring specific skills in understanding and interpreting women’s responses and being able to attune to the needs of the woman, their strengths and capabilities. The importance of being flexible, establishing a relationship and working collaboratively is central to this complex process (Browne, Briggs, Kemp et al.). Browne (2009) adds that this requires high level of negotiation and complex decision-making skills.

As this study highlights, the use of other skills such as the observation of the environment and the interaction between mother and baby are all elements that build the story for CFHNs around a woman’s needs. Some argue this work of observation is central to the clinical skill of the nurse and or midwife. Wilson (2001) in her work with nurses in New Zealand describes this ‘surveillance’ as being similar to, or part
of, public health surveillance that is undertaken, for example, to monitor the spread of disease. In this context public health surveillance is considered a routine and unproblematic aspect of CFHN practice (Wilson). This type of surveillance includes observing the woman and taking into consideration aspects related to physical, emotional and development of the infant and the broader context of the family. Wilson (2001) argues that this practice provides a greater perspective of ‘what is going on’ in the home environment and assists to inform the CFHN about the woman’s situation (Wilson). However, some women may, and do, find this intrusive, even objectionable, and may be left feeling powerless and even vulnerable (Liaschenko, 1994). Surveillance can occur in both the home and the clinic setting but clinicians may underestimate the impact that this has on women (Spangaro, 2010).

It is importance to identify the tensions experienced by midwives and CFHNs who know that they are covertly and even overtly watching women, and conducting 'assessments' is sometimes code for formulating judgements. In an attempt to reduce the impact of surveillance Jack et al. (2005) describes that health professionals attempt to overcome fear experienced by families, indicating that there may be a power differential that needs to be moderated. Women may comply with assessment to accommodate the nurse and wanting to be perceived as a ‘good mother’ as described by Wilson (2001). Similarly Peckover (2002) considers clinicians’ ‘pastoral power’, where personal thoughts may be shared through confessional techniques. These ideas fit with Foucault’s concepts of power and surveillance, raising ethical issues that underpin clinical practice and challenge nurses perceptions of their supportive role (Marcellus, 2005). Yelland (2007) explains women have a
sense they are being assessed or surveyed and feel uncomfortable despite attempts by health professionals to abate their discomfort.

The CFHNs in this study appear to consider the impact of the baby’s wellbeing on the woman’s social and emotional wellbeing and assess how this may interfere with the women’s abilities to conduct daily activities around the house and how it affects her capacity to maintain relationships with family and friends. CFHNs placed greater emphasis on their clinical assessments than on women’s response to structured tools. Helping them formulate individualised plans, whilst taking into consideration the whole picture. This is similar to the findings of Armstrong and Small (2006) where maternal child health nurses in Victoria rely on their own assessments which often override protocols. Appleton and Cowley (2004) emphasise that CFHNs/health visitors in the UK, rely on their own professional judgement in making family assessments even when guidelines exist. Borrow (2011) conclude that nurses working at this expert level have highly developed skills in critical analysis, problem solving and decision making.

Australian studies such as Kardamanidis et al. (2009), describe the skills required by CFHNs to engage in a flexible or relationship style approach to assessment as ‘actively-passive’. Not engaging in active tasks such as the baby check but merely being with the woman and observing the signs and signals from the woman that may indicate areas of strength and how to build on these. These passive yet active (Kardamanidis et al. 2008) discussions ‘over coffee’ (Browne, 2009) are perceived by health professionals to allow for a more relaxed flexible conversation about risk factors and their potential impact on children and the family (Fowler et al., 2012, Kardamanidis et al., 2008). Whilst this approach to assessment and screening appears to reflect a flexible approach, Almond and Lathlean (2009) highlight that
CFHNs in the postnatal period rely on the information gathered in the antenatal assessment and that if this is not done in a structured and well documented way CFHNs will not get the information they require. CFHNs may rely on women having heard about screening for depression antenatally and do not feel the need to explain it in great detail. In this study CFHNs often introduced the EPDS with ‘you would have seen this before’.

CFHNs in this study comment they know that their role ends with the referral of women to other services, which they are able to identify. Rush (2012) similarly describes the importance of CFHNs building rapport and their role in continuity with women. CFHNs identified part of their role as coordinators of the referral of women to other services. However, this study identifies challenges in respect of providing mental health services. Pathways for referral exist across this study’s sites, however, midwives and CFHNs feel dissatisfied with mental health services lack of response to their requests for consultation which makes working relationships and partnerships challenging.

10.2.7 Impact of psychosocial assessment process on women

Assessment of women’s social and emotional wellbeing is conducted in NSW by midwives and CFHNs. The rationale for assessment is to promote the early identification of women who are vulnerable/demonstrate psychosocial risk and to provide timely responses and services provision if necessary (Karatas et al., 2009, Health, 2009, Buist et al., 2007). In this study, I observed how women responded to being asked psychosocial assessment questions at different time points, before and after birth, women generally felt the questions were important and appeared to cooperate with the midwife or nurse asking the questions. However, this may not indicate that these women had a positive experience. Women, in this study, who did
disclose previous negative life events experienced distress, however, they did not appear to express their discomfort during the assessment by the health professionals. This response may have been to ensure that they maintained these relationships as discussed below.

Women’s reflections on being asked the psychosocial assessment questions were generally positive. The women perceive being asked the questions as a sign of caring on the part of the clinician and this reflected positively on the health service being provided. Although surprised by the questions, women indicated that the health service and care was of a high standard because clinicians were interested in their social and emotional wellbeing. Some of the women, born in countries outside of Australia such as Egypt and where English was not their first language, stated that this was the first time they had been asked questions like this and, for them, this reflected positively on the health service overall. Women’s positive experiences of the psychosocial assessment questions have been reported in other literature (Leigh and Milgrom, 2007, Buist et al., 2006b, Matthey et al., 2004) and who particularly emphasised the acceptability that women have towards depression screening.

In contrast to these positive experiences there were women in this study who felt distressed when they disclosed a previous negative life event during psychosocial assessment. Reports from other studies indicate that the questions are perceived as ‘peculiar’ (Hegarty et al., 2007). Similarly in this study women found them ‘funny’ or ‘surprising’ and expressed they did not expect the questions. Researchers (Cowley et al., 2004) warn about the dangers of not preparing women for being asked these sensitive questions, and that this may discourage women from disclosing negative life events. This study’s findings emphasise that, although women were uncomfortable talking about previous negative life events, they remained engaged
with their midwife or CHFN and did share personal and sensitive details. Some women described that they required support following disclosure of a previous negative life event, some women required support and this was mostly provided by their partners.

The impact of disclosure of a negative life event is largely mediated by an individual’s capacity to manage their distress through the telling of the story such as a sexual abuse history (Palesh et al., 2007). In psychotherapeutic settings, such as individual counselling, direct questioning of previous experience of a negative life event or sexual abuse is discouraged as it can lead to distress and may trigger symptoms of post-traumatic stress disorder associated with survivors of sexual abuse. Self-disclosure of abuse over a longer period of time is preferred when the clinician-client relationship is established (Faber et al., 2009). This is in contrast to the practice of asking the psychosocial assessment questions usually at the first visit a woman has with a midwife or CFHN. It remains unclear as to the impact the disclosure may have on the woman and whether midwives and CFHNs are made aware of the longer term impact and the need for mental health intervention.

For some women and for many professionals, it may be preferable to conduct the psychosocial assessment after establishing a relationship (Kardamanidis et al., 2008, Rowe and Barnes, 2006). Women’s contact with the same clinician, being either a midwife or CFHN, at subsequent visits may be effective in supporting women and health professionals in the process of psychosocial assessment. The midwifery continuity of care model, where a woman receives all her pregnancy birth and postpartum care from one or a small group of known midwives emphasises the importance of the midwife-woman relationship and its central characteristics of trust and reciprocity (Hunter, 2008, Hunter, 2006). Nurses develop experience of working
in partnership over time reflecting and developing expertise (Hopwood et al., 2013). As the relationship between the woman and the midwife or CFHN develops, questions may be introduced over time. Davis and Day (2010) report that the development of a relationship and shared understandings over time between midwife/nurse and the woman/family may lead to a greater likelihood that sensitive issues will be disclosed.

Although, the women in this study were distressed at the time of disclosure of sensitive information, they were generous with the level of detail they shared. This study found that women engaged in a level of compliance when being asked these sensitive questions and may feel they need to respond. There is little research regarding compliance in the context of psychosocial assessment, however, it is widely known that women are most likely to comply during pregnancy with medical treatment; such as antenatal testing (Ward et al., 2000).

Women in this study encountered psychosocial assessment at the first meeting with the midwife. As the women are unprepared for this experience, they may disclose information that, at other times or when more prepared, they may choose not to disclose. As Palesh et al. (2007) reports, if a woman unexpectedly feels pressure to respond to a sensitive question she may provide tentative disclosures whilst masking her discomfort and distress (Palesh et al.). Disclosure may be a compliance response or may relate to anxiety surrounding the new encounter with midwifery and nursing services and wanting to be perceived as agreeable to the care provided.

Women in this study described a more positive experience following their disclosure if the midwife or nurse provided a sensitive and caring response. As Poor
(2011) report if women feel that they are being prioritised and not judged, they are more likely to feel optimistic following their interaction with the midwife or nurse.

Women in this study described how they sought emotional support from their partners when they experienced distress during the psychosocial assessment process. Across both sites, partners had little or no involvement in the psychosocial assessment and at times are excluded from the entire maternal care visits, for example, the antenatal booking visit. This creates tension for some women, as they report that their partners react with anger and frustration, at times directing this towards the health professionals. Partners excluded from the process perceived that the women or health service are hiding aspects of care from them. As one partner observed in a remark to the midwife ‘she’s got nothing to hide’.

Involvement of prospective and new fathers in a child's life is important (Fletcher et al., 2008) and midwives are well placed to engage with fathers and include them in the planning of appropriate care for their newborn (Health 2009). During the implementation of NSW Safe Start policy, partners were excluded from psychosocial assessment process but, conversely, they appear to be the primary support provider for women in this study following a negative experience of the assessment process.

When partners were present during part of the visit, midwives and CFHNs altered their approach to the introduction and or the way in which they were asked to leave prior to the psychosocial assessment. The approach taken to explaining to partners why they were asked to leave at times lacked sensitivity i.e., ‘we’re just going to talk about you now’ and may have provoked suspicion on the part of the partners. Women in this study did describe that their partners indicated to them that they were aware of, or had some sense of, the types of questions that were being
asked of the women. How midwives or CFHNs dealt with partners and their exclusion from the visit may impact on the partner’s experience. However in this study the partner’s experience was not explored in direct interviews with them but rather through the women’s descriptions of their experience and observing the interactions.

In some instances in the postnatal period, CFHNs were observed to provide partners with the EPDS to complete whilst waiting for the woman’s psychosocial assessment to be completed. In one instance a partner’s score had exceeded the woman’s; however, this was not further explored by the nurse. Goodman et al. (2004) and Dudley et al. (2001) describe, CFHNs’ initiative in conducting depression screening with partners emphasises that postpartum depression and psychosocial issues affect the whole family. Screening partners for depression can be conducted using the EPDS, as suggested by Fisher et al. (2012b); however, connecting men with clinical services may be present challenges.

Engagement with partners during maternal care has implications for enhancing relationships and may influence women’s disclosure of social and emotional concerns (Massoudi, 2013). In this study, when the midwife asked about a family history of mental illness when the partner was present, it facilitated further discussion about the partner’s mental health needs and this was explored in the context of how this was impacting on the woman. Involvement of partners in aspects of the process of psychosocial assessment such as family history of mental illness or stressors related to becoming a new parent, may be beneficial in assisting women and partners to disclose social and emotional wellbeing concerns, however, further research is needed and recommended.
10.2.8 Implementation of Safe Start policy into practice

This study demonstrates that although psychosocial assessment and depression screening is identified as an important aspect of midwifery and nursing care, there are varying perspectives in its implementation across both site A and site B. Differences were largely in relation to the points in time where assessment and screening process were implemented and whether structured tools were used or not. Difficulties and challenges may arise such as the timing and frequency of uptake by clinicians, when implementing clinical guidelines into practice (Grol and Grimshaw, 2003). Implementation issues are evident in the varying practices of the SFE policy recommendations for psychosocial assessment. This may provide some explanation for the tensions experienced by midwives and CFHNs and the impact of incorporating structured tools into flexible relationship based approach. Potentially there are both positive and negative consequences of a state level policy designed to be interpreted at the local level. This may also mean that CFHNs undertake the challenging work of psychosocial assessment and depression screening in diverse and perhaps, in some cases, ineffective ways (Cowley & Houston 2003, Shakespeare, 2003).

Recommendations for the implementation of the psychosocial assessment in the SFE policy appeared to be broad and open to interpretation; this may be problematic. As Guillery et al. (2012) found, protocols may lack specificity, rendering them difficult to interpret and implement. They found, for example, that the lower frequency of CFHNs conducting domestic violence screening may have resulted from insufficient protocols. They suggest that poor implementation of the policy into practice may relate to CFHNs lack knowledge of the protocols (Guillery et al.). On the one hand, the SFE policy allows local services to identify and meet
their specific population needs and to deploy the available workforce in an appropriate way and provide targeted training and education. On the other hand, it may be that the policy lacks specificity such as how the questions are to be delivered or approached and the actual timing of assessment. Therefore, there is the potential for inconsistency across and within local health district areas.

In recent years the roles of both midwives and CFHNs developed, expanded and changed (Borrow et al., 2011, Homer et al., 2009). In the context of psychosocial assessment a move to introduce structured protocols may be rejected by clinicians who have developed advanced skills in critical analysis and problem solving when assessing women and families (Borrow et al., (Appleton, 2008). From this study midwives appear to be routinely asking the assessment questions, whereas CFHNs are less likely to conduct assessments but all depression screening process are in place. One explanation for this may also be that the CFHNs participating in this study were in different stages of implementing the change in assessment and screening process and were anticipating the arrival of computer based structures that will include psychosocial assessment. Myors et al. (2011) describes how CFHNs were overwhelmed by the many changes to their clinical practice, perceiving changes as additional burdens, which may inhibit policy implementation (Myors et al.).

Individual clinicians may not support or be ready for the change which may result in inconsistencies in practice. As explained by Grol and Grimshaw (2003) implementation is enhanced when clinicians identify with and consider the change that is required to be of value to themselves and of to benefit the clients.

Implementation of new policy and practices within health care environments may take time and may result in inconsistencies in practice amongst individuals in teams (Damschroder et al., 2009). As Armstrong & Small (2007) describe the frequency of
screening is more likely to increase the more familiar professionals are with the process.

Midwives and CFHNs in this study comment that there have been few educational and training resources provided for the implementation of assessment and screening process. Many of the participants explained they were provided with training at the time of implementation, some years previously and acknowledged that online training was available. However, few of this study’s participants, midwives and CFHNs, had completed the online training. Commentators in the field (Appleton and Cowley, 2004), Shakespeare, 2003) advocate for the ongoing training of health professionals and comments that this may be an aspect of professional practice that inhibits the assessment and screening process. Some organisations have incorporated roles specifically to support implementation of SFE within local health districts in NSW. However, Schmied et al. (2010) highlighted that the impact of these positions and their support for implementation and change process is not evident in practice as inconsistencies still exists.

10.3 Implications for practice

10.3.1 Support and training of clinicians

Organisations’ approach to implementation of policies, such as SFE regarding psychosocial assessment and depression screening process, requires planning, ongoing active monitoring of implementation process, training and support (Gutmanis et al. 2007, (Marron and Maginis, 2009), Mollart and Newing 2009). This study highlights the importance of local plans for implementation assessment and screening policies that clarify expectations for clinicians, monitor resources and training and provide support. In this study most midwives and CFHNs reported that
education and training had been provided initially when the implementation assessment and screening questions were first introduced but very few supports since that time had been offered since.

Most observations reveal that the individual style of the midwife or CFHN was conducive to women feeling comfortable to talk to them. Although, modifications to questions or the arrangement of the assessment differed between midwives and CFHNs, they were generally sensitive to the women’s concerns and personal experiences. At times midwives and CFHNs were observed to ask the sensitive questions through their own understandings and interpretation, indicating to the woman how they would feel about answering the questions themselves. This highlights the ongoing need for support and supervision for midwives and CFHNs to explore the sensitive nature of these questions and opportunities to discuss their own experiences of listening and responding to trauma stories. Additionally, the need for ongoing education is required around how to approach these sensitive questions, respond to positive answers and debrief women following disclosure. Consideration of the time allocated to build these relationships may be one factor that could enhance the implementation of the policy in regard to assessment process (Schmied et al. 2010, (Yonaka et al., 2007). However, in one context they had an hour and a half which appeared to be sufficient even when extra needs were identified.

Midwives and CFHNs in this study report they had to learn to adapt their practice to recent policy needs and to do this have simply ‘learnt on the job’. Overcoming challenges in communicating with women about these sensitive issues requires observing the practice of others (Marron and Maginis 2009) and obtaining peer support from colleagues around disclosures and how to deal with them (Mollart and Newing 2009). Midwives and CFHNs identify that if they had adequate support
and training they would feel more comfortable conducting assessment and dealing with women’s disclosures. Safe Start online training was made recently available, however, midwives and CFHNs revealed in discussion groups that few had undertaken this online training. A focus on providing midwives and CFHNs with ongoing education, training and support may also result in more consistent approaches to the delivery of assessment and screening process. Currently many midwives and CFHNs feel that they are inadequately prepared to undertake psychosocial assessments and describe having limited skills in eliciting and responding to sensitive information and the needs of women and families (Browne et al. 2009, Kruske et al. 2006).

Researchers (Hegarty et al. 2007, Buist et al. 2006, Cowley & Houston 2003) who have investigated the skills required by health professionals conducting psychosocial assessments, have raised concerns about the level of skill and the approach adopted. They suggest that rather than a debate about flexibility verses structured approaches, policy makers should be considering the support midwives and CFHNs require to assist them to develop the skills required to undertake assessment and screening effectively (Hegarty et al., Buist et al., Cowley & Houston).

10.3.2 Preparation of women

Preparing both the professional and the family adequately for the assessment process and sensitive questioning could be further emphasised in practice. Women may be better prepared if they were provided with leaflets or brochures prior to visits clearly stating the purpose of the visit. Women expressed in this study that they perceived the visit as being about the baby and that the CFHNs postnatally arranged appointments for the ‘baby check’. Consideration of the language used to promote
visits could be revised when women make appointments; new language may include ‘whole family assessment’ or ‘well baby and family assessment’. The role of community education could be considered regarding the expansion of the role of midwives and CFHNs in assessment of women’s social and emotional wellbeing and could be promoted through various means. Promotion could include the preparation and participation of partners and benefit the psychosocial wellbeing of families.

Appropriate responses to screening results and referral pathways

Buist et al. (2007) emphasise the importance of robust referral pathways for women who have elevated EDS/EPDS to ensure adequate health service provision is in place to support the ongoing monitoring and assessment of women’s social and emotional wellbeing. Participating midwives and CFHNs indicated frustration with regard to the lack of response from mental health services to the screening outcomes and this may have implications for practice. Psychosocial assessment processes need to be followed up with appropriate recording and timely referral of women/families to services.

10.3.4 Impact of environment

As was discovered in this study’s findings women responded positively to environments where the clinic rooms appeared friendly and were decorated in personal memorabilia from other new mums thanking the midwife or nurse. The carpeted floor coverings and rooms that provided insulation or were removed from busy clinic areas were more conducive to private conversations. Therefore, organisations, midwives and CFHNs may consider the implications of creating environments that facilitate and promote comfort for women when entering environments where personal and sensitive information is shared.
10.4 Study limitations

This study is based on small numbers of observations but the commonalities expressed by participants suggest similarity in participants’ experiences and provides a richness of qualitative data that may be related to similar settings. As an in depth ethnographic study, the sample size of 34 women is appropriate, however a third of these women were not available for observations following birth. Most of the women who agreed to participate were well educated with 90% holding tertiary qualifications and they may not, therefore, adequately reflect the experiences of women who have lower levels of education. Not all midwives who were provided with information and in-service had agreed to participate in the study and it may be that those who did not participate had different approaches to this assessment or felt more or less confident with the process. Nor is it known whether or not the data obtained from the large group discussions was impacted or different from the data that was expected if the data collection had occurred in smaller focus groups as planned. The study sample included highly experienced CFHNs, who may have felt more confident to participate in the research.

This study was also conducted across two sites that differed in the locations where assessments are conducted. Assessments were completed at home or clinic visits at two different points in time, two weeks versus six weeks following birth. Some of the differences in the interactions observed may have, therefore, occurred because the infant was two weeks versus six weeks old or because of the location.
10.5 Recommendations for future research

The women participants in this study were from diverse cultural backgrounds. This study provided some analysis of the experiences of these women, including how they perceived the assessment process. This study also reported on clinicians’ varying approaches to the challenges of assessing and screening women from different cultural backgrounds. How clinicians assess and formulate decisions regarding the intervention that are required for women is under reported in this context and would benefit from some further research (Vanderburg, 2010). Further research could be conducted to investigate the implementation of the psychosocial assessment questions across cultures; with migrant and refugee women living in Australia. Future studies could explore the cultural appropriateness of the psychosocial assessment questions and the clinical skills required to conduct psychosocial assessment with the growing populations of women from diverse backgrounds in the Australian community.

This study provided the opportunity to observe how partners or others in attendance with women, at the visits were dealt with in the context of psychosocial assessment process in NSW. Observing components of the clinical interactions, demonstrated how clinicians negotiate partner involvement. Interviews with women explored their responses to partners being asked to leave. Women also reflected on their partners responses following the visits.

The researcher’s observations and interviews, exploring women’s perspective of the involvement of their partners and the role of partners in maternal care, adds new knowledge. Analysis and interpretation was limited in that the study did not directly include partners’ perceptions. Further research is needed to explore directly the impact on partners or those who attend with women at the visits where
assessment and screening is conducted and whether there is validity in conducting assessments with partners.

Similarly, the researcher did not analyse the longer term impact of disclosure of negative life events on the women, nor the process of referral to and accessibility of services following a disclosure. Participants in discussion groups alluded to challenges regarding accessibility to mental health services. Further research is needed to explore availability of service provision, service pathways and accessibility of specialist services such as mental health, in response to a disclosure and the impact this may have on women.
10.6 Conclusions

Although the NSW Safe Start policy recommends that the set of preferred psychosocial assessment questions be incorporated as routine practice by midwives before birth and by CFHNs after birth for all women, there were varying adaptations of these policy recommendations between study sites, particularly in the postnatal period. Midwives appeared to adapt well to the use of structured tools and process in psychosocial assessment and feel having the questions in a data base improved their practice. However, midwives still emphasise the importance of incorporating these tools into a flexible and/or relationships based approach with the women. CFHNs conducting psychosocial assessment in the postnatal period appeared to adopt a flexible relationship based approach from the commencement of engagement with the women. The challenge for CFHNs appeared to be incorporating a tool for assessment and screening. Some of the CFHNs did not ask the psychosocial assessment questions as they perceived they were able to conduct assessment using other skills. Generally, women appeared to respond positively to being asked the psychosocial questions; however they did experience distress following disclosure. Women described the approach of their midwife or CFHN influencing their experience. Women who experienced discomfort in being asked the questions did not share this with their midwife or nurse. Rather women appeared to comply by responding to the questions and later sought support following disclosure from their partner or other in attendance.

The study’s findings emphasise that creating comfort for women and clinicians during assessment is important. The policy recommendations and the requirement of midwives and CFHNs conducting assessment are currently open to interpretation. This may offer flexibility for midwives and CFHNs to become more
autonomous and flexible in their approach to implementing assessment and screening process. However, if current policy, such as Safe Start, is to continue to be implemented within health services, then organisations need to ensure that there is a thoughtful plan as to how to support, educate and train midwives and CFHNs in the development of relationship with women and their partners in the context of carrying out assessments. Consideration is also needed to explore how to support women who don’t have supportive family or partners. The training needs to include education on the delivery of the assessment questions, how to respond to disclosure of previous negative life events in a sensitive and caring way and access to clinical supervision is crucial.
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Appendices
Appendix A Edinburgh Postnatal Depression Scale (EPDS)

Edinburgh Postnatal Depression Scale\(^1\) (EPDS)

Name: ___________________________ Address: ___________________________

Your Date of Birth: ___________________________ Baby's Date of Birth: ___________________________

Phone: ___________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. I have looked forward with enjoyment to things
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. I have been anxious or worried for no good reason
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

*5 I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

*6. Things have been getting on top of me
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

*8 I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

*9 I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

*10 The thought of harming myself has occurred to me
   - Yes, quite often
   - Sometimes
   - Hardly ever
   - Never

Administered/Reviewed by ___________________________ Date ___________________________


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Appendix B Safe Start questions

<table>
<thead>
<tr>
<th>Variables (Risk Factors)</th>
<th>Suggested format for psychosocial assessment questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Lack of support</td>
<td>1. Will you be able to get practical support with your baby?</td>
</tr>
<tr>
<td></td>
<td>2. Do you have someone you are able to talk to about your feelings or worries?</td>
</tr>
<tr>
<td>II. Recent major stressors in the last 12 months.</td>
<td>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?</td>
</tr>
<tr>
<td>III. Low self-esteem (including lack of self-confidence, high anxiety and perfectionist traits)</td>
<td>4. Generally, do you consider yourself a confident person?</td>
</tr>
<tr>
<td></td>
<td>5. Does it worry you a lot if things get messy or out of place?</td>
</tr>
<tr>
<td>IV. History of anxiety, depression or other mental health problems</td>
<td>6a. Have you ever felt anxious, miserable, worried or depressed for more than a couple of weeks?</td>
</tr>
<tr>
<td></td>
<td>6b. If so, did it seriously interfere with your work and your relationships with friends and family?</td>
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<tr>
<td></td>
<td>7. Are you currently receiving, or have you in the past received treatment for any emotional problems?</td>
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<tr>
<td>V. Couple’s Relationship Problems or Dysfunction (if applicable)</td>
<td>8. How would you describe your relationship with your partner?</td>
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<tr>
<td></td>
<td>9. a) Antenatal: What do you think your relationship will be like after the birth?</td>
</tr>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>b) Postnatal (in Community Health Setting): Has your relationship changed since having the baby?</td>
</tr>
<tr>
<td>VI. Adverse childhood experiences</td>
<td>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)?</td>
</tr>
<tr>
<td>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</td>
<td>11. Within the last year have you been hit, slapped, or hurt in other ways by your partner or ex-partner?</td>
</tr>
<tr>
<td></td>
<td>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)</td>
</tr>
<tr>
<td></td>
<td>13. Are you safe here at home/to go home when you leave here?</td>
</tr>
<tr>
<td></td>
<td>14. Has your child/children been hurt or witnessed violence?</td>
</tr>
<tr>
<td></td>
<td>15. Who is/are your children with now?</td>
</tr>
<tr>
<td></td>
<td>16. Are they safe?</td>
</tr>
<tr>
<td></td>
<td>17. Are you worried about your child/children’s safety?</td>
</tr>
<tr>
<td></td>
<td>18. Would you like assistance with this?</td>
</tr>
<tr>
<td>Opportunity to disclose further</td>
<td>19. Are there any other issues or worries you would like to mention?</td>
</tr>
</tbody>
</table>
Appendix C Focus Group Questions CFHN

Although Safe Start has only been introduced in policy in 2009, this is something you have been doing for quite some time; we are hoping to capture your knowledge and experience in doing this in this discussion.

1. Can you tell us about your experience of conducting Psychosocial assessment and depression screening:
   a. Do you use the SSQ’s?
   b. Do you use the EPDS?
   c. Prompts – can you recall how you felt when you had to ask these questions the first few times?
   d. How do you feel about doing it now?
   e. How do you feel about asking the domestic violence screening questions? Are you comfortable with the wording? (Maybe) Do you think there could be a different approach to these questions?

2. How do you think women are prepared for what is entailed in the home visit?
   a. What do you hope to achieve in the first home visit?

3. What has helped you to incorporate psychosocial assessment and depression screening into your practice?

4. What challenges have you or your colleagues faced?

5. What are your views on conducting depression screening with the EDS? In your experience what have you found to be the best way to use the EDS?
   a. (Prompt) for example in what part of the interview you would ask the woman to complete the tool. Once the woman has completed the tool and you notice it is high – how do you address this with women?

6. I am also really interest in how you might use your clinical judgment in the process of assessment Can you describe for me the cues that give you a hunch, about something. E.g. Strong sense something’s not right, don't get responses or get the opposite what expecting?
7. In what way has your practice changed since you have been incorporating these assessments in your practice?

8. What, if anything, do you feel has prepared you for working in this way?

9. What training and support have you been offered and what have you participated in for screening and assessment?

10. How do you perceive the use of computers will affect this process?

11. Is there anything else you would like to add?
### Appendix D Table 2. Interview questions

<table>
<thead>
<tr>
<th>Questions from researcher to woman in private interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall how did you find the being asked the questions related to your personal situation? (the psychosocial assessment questions)</td>
</tr>
<tr>
<td>2. Were there any questions that you felt were helpful?</td>
</tr>
<tr>
<td>3. Were there any questions you felt were uncomfortable or more difficult to answer?</td>
</tr>
<tr>
<td>4. Was there anything particular your midwife or nurse did that made you feel comfortable?</td>
</tr>
<tr>
<td>5. Do you have any thoughts about what could be done differently to help other women being asked these questions?</td>
</tr>
</tbody>
</table>
Appendix E Focus Group Questions as discussed

Although Safe Start has only been introduced in policy in 2009, this is something you have been doing here for quite some time; we are hoping to capture your knowledge and experience in doing this in this discussion.

1. Can you tell us about your experience of conducting Psychosocial assessment and depression screening:
   a. Prompts – can you recall how you felt when you had to ask these questions the first few times in a booking visit?
   b. How do you feel about doing it now?
   c. How do you feel about asking the domestic violence screening questions?
   d. Are you comfortable with the wording? (Maybe)
   e. Do you think there could be a different approach to these questions?

2. What challenges have you or your colleagues faced?

3. What has helped you to incorporate psychosocial assessment and depression screening into your practice?

4. What are your views on conducting depression screening with the EDS? In your experience what have you found to be the best way to use the EDS?
   a. (Prompt) for example in what part of the interview would you ask the woman to complete the tool. Once the woman has completed the tool and you notice it is high – how do you address this with women

5. I am also really interest in how you might use your clinical judgment in the process of assessment - Can you describe for me the cues that give you a hunch, about something e.g. Strong sense something’s not right, don't get responses or get the opposite what expecting

6. In what way has your midwifery practice changed since you have been incorporating these assessments in your practice?

7. What training and support have you been offered and what have you participated in for screening and assessment?

8. Is there anything else you would like to add?
Dear Potential Participant,

We, at the University of Western Sydney, write to inform you of an opportunity to participate in our study which hopes to gain information that will improve midwifery and child and family health services and ultimately improve women’s experience of care during the perinatal period from conception until after the birth of your child.

We are routinely sending information about our study to women who have recently booked at the (Royal Hospital for Women / Liverpool Hospital) Antenatal Clinic. We hope to invite women to participate in this study and have included an information brochure which briefly explains what the study is about and what participation in the study would involve.

You may be approached when you attend the Antenatal clinic by our researcher who will be available to discuss the study further with you.

If you would like to know more about this study or express your interest in participating, please contact Mellanie Rollans, who will discuss it with you further and answer any questions you may have. Please feel free to contact her on 0437 864 232.

Thank you for considering this opportunity,

A/Prof Virginia Schmied                     Ms Mellanie Rollans
University of Western Sydney                University of Western Sydney

---------------------------------------------------------------------------------------------------------------------------------

Signature                     Signature

...../ ...../ .........                     ...../ ...../ .........
Appendix G

Royal Hospital for Women
Barker Street
Locked Bag 2000
Randwick NSW 2031
Tel: (02) 9382 6111
Fax: (02) 9382 6513

Consent form for Midwives and Child and Family Health Nurses (CFHN):
The Perinatal Journey:
The Process, Impact and Outcomes of
Psychosocial Assessment

I agree to participate in the above research project and give my consent freely.

I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.

I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I consent to having interactions observed between myself and a pregnant woman or new mother, during the psychosocial and depression screening, at the booking visit or the Universal Health Home Visit (UHHV) or the early Child care Centre.

Yes  No  N/A

I consent to participate in a brief interview at a time convenient to myself.

Yes  No  N/A

I consent to participate in a focus group.

Yes  No  N/A

I understand that I can ask for the observations to be stopped at any time.

I understand that my personal information will remain confidential to the researchers.

I have the opportunity to have questions answered to my satisfaction.

Print Name:
Signature: Date:

Contact Details:

I have informed the above person about this research and am sure that they understand both the content of the information statement and the additional information I have provided.

Print Name:
Signature: Date:
Appendix H

Royal Hospital for Women
Barker Street
Locked Bag 2000
Randwick NSW 2031
Tel: (02) 9382 6111
Fax: (02) 9382 6513

Consent form for participating women:
The Perinatal Journey:
The Process, Impact and Outcomes of Psychosocial Assessment

I agree to participate in the above research project and give my consent freely.
I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.
I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing
I agree to being observed during my antenatal booking visit

Yes  No
N/A

I agree to be interviewed at my second visit to the antenatal clinic

Yes  No
N/A

I agree to be observed during my visit with the Child and Family Health Nurse

Yes  No
N/A

I agree to be interviewed following my visit to the Child and Family Health nurse at the Early Child Care Centre (baby health care clinic)

Yes  No
N/A

I understand that my involvement is confidential and that the information gained during the study may be published but no information about me will be used in any way that reveals my identity.
I understand the data collected in this study may be included in a larger study evaluating the outcomes of women in the perinatal period.
I have the opportunity to have questions answered to my satisfaction.

Print Name:  
Signature:  Date:

Contact Details:
I have informed the above person about this research and am sure that they understand both the content of the information statement and the additional information I have provided.

Print Name:  
Signature:  Date:
Appendix I  Consent form for Midwives and Child and Family Health Nurses (CFHN):

The Perinatal Journey:
The Process, Impact and Outcomes of Psychosocial Assessment

I agree to participate in the above research project and give my consent freely.
I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.
I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.
I consent to having interactions observed between myself and a pregnant woman or new mother, during the psychosocial and depression screening, at the booking visit or the Universal Health Home Visit (UHHV) or the early Child care Centre.

Yes  No  N/A
I consent to participate in a brief interview at a time convenient to myself.

Yes  No  N/A
I consent to participate in a focus group.

Yes  No  N/A
I understand that I can ask for the observations to be stopped at any time.
I understand that my personal information will remain confidential to the researchers.
I have the opportunity to have questions answered to my satisfaction.
Print Name:
Signature: Date:
Contact Details:
I have informed the above person about this research and am sure that they understand both the content of the information statement and the additional information I have provided.
Print Name:
Signature: Date:
Consent form for participating women:

The Perinatal Journey:
The Process, Impact and Outcomes of
Psychosocial Assessment

I agree to participate in the above research project and give my consent freely.
I understand that the project will be conducted as described in the Information Statement, a copy of which I have retained.
I understand I can withdraw from the project at any time and do not have to give any reason for withdrawing.

I agree to being observed during my antenatal booking visit

- Yes
- No
- N/A

I agree to be interviewed at my second visit to the antenatal clinic

- Yes
- No
- N/A

I agree to be observed during my visit with the Child and Family Health Nurse

- Yes
- No
- N/A

I agree to be interviewed following my visit to the Child and Family Health nurse at the Early Child Care Centre (baby health care clinic)

- Yes
- No
- N/A

I understand that my involvement is confidential and that the information gained during the study may be published but no information about me will be used in any way that reveals my identity.

I understand the data collected in this study may be included in a larger study evaluating the outcomes of women in the perinatal period.

I have the opportunity to have questions answered to my satisfaction.

Print Name:
Signature: Date:

Contact Details:
I have informed the above person about this research and am sure that they understand both the content of the information statement and the additional information I have provided.

Print Name:
Signature: Date:
Appendix K Information for Midwives and CFHNs

The Perinatal Journey: The Process, Impact and Outcomes of Psychosocial Assessment

INFORMATION FOR MIDWIVES AND CHILD AND FAMILY HEALTH NURSES

Introduction
You are invited to take part in a research study into the process and impact of the psychosocial assessment; this assessment is undertaken by midwives during the antenatal booking visit and by child and family health nurses (CFHN) in the postnatal universal home visit. We want to explore how nature of the assessment influences women and families to engage in ongoing services. The study also, aims to determine the relationship between social and emotional health in pregnancy and after birth, and the use of health services and outcomes for women and their infants at 6 weeks and 6 months after birth.

In NSW it is routine to ask all women before and after birth about their social and emotional wellbeing. The purpose of this study is to see if there is a link between any potential concerns or needs identified by the midwife or CFHN during psychosocial assessment and depression screening and whether women choose to use services or supports offered by the midwife or CFHN. We are also interested in your experience of conducting the psychosocial assessment and depression screening in particular your approach and style around asking the questions during the interview.

The study is being conducted within this institution by Associate Professor Virginia Schmied (University of Western Sydney), Dr Lynn Kemp (University of New South Wales), Dr Tanya Covic (University of Western Sydney) and PhD candidate Mellanie Rollans (University of Western Sydney). The study is part of a collaborative study in partnership Karitane a child and family care service in NSW. The study is being sponsored by the Australian Research Council Linkage Project and the University of Western Sydney.

Study Procedures
If you agree to participate in this study, you will be asked to sign the Participant Consent Form. You will then be asked to undergo the following procedures:

If you are a midwife:

1. You will be asked for permission to observe during your interaction with up to three women at their first Antenatal booking visit. Observations will be around the interaction between yourself and the woman during psychosocial assessment and depression screening.

2. Subject to your availability you may also be asked to participate in an interview and/or focus group that will explore information regarding your perceptions of
If you are a Child and Family Health Nurse:

1. You will be asked to be observed during your interactions with up to three women at the Universal Health Home Visit (UHHV) or the Early Child Care Centre (baby health care clinics). Observations will be around the interaction between yourself and the woman during psychosocial assessment and depression screening.

2. Subject to your availability you may also be asked to participate in an interview and/or focus group that will explore information regarding your perceptions of conducting the assessment and screening. This will last approximately one hour to be arranged at a later time.

Risks

Your participation in this study involves observation of interactions between midwives and CFHNs’ and the antenatal and postnatal women, and an interview and/or focus group session. It is not expected to cause you any discomfort. If you are uncomfortable being observed, remember that participation in this study is completely voluntary and you can withdraw at any time without any consequences.

Benefits

While we intend that this research study will help improve midwifery and child and family health services and ultimately improve women’s experience of care during the perinatal period from conception and post delivery in the future, it may not be of direct benefit to you.

Costs

Participation in this study will not cost you anything, nor will you be paid.

Voluntary Participation

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason.

Confidentiality

All the information collected from you for the study will be treated confidentially, and only the researchers named will have access to it. The study results may be presented at a conference or in a scientific publication, but individual participants will not be identifiable in such a presentation.

Further Information

When you have read this information, Mellanie Rollans will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact her on 0437 864 232.

This information sheet is for you to keep.

Ethics Approval and Complaints

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney South West Area Health Service. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number X??-0???.

The conduct of this study at the Royal Hospital for Women has been authorised by Sydney South West Area Health Service. The conduct of this study at the Liverpool Hospital has been authorised by South Eastern Sydney Illawarra Area Health Service. Any person with concerns or complaints about the conduct of this study may
also contact the Research Governance Officer [or other officer] on [telephone number] and quote protocol number [insert local protocol number].

Thank you for considering this invitation

Signatures

A/Prof Virginia Schmied Ms Mellanie Rollans
University of Western Sydney University of Western Sydney

...................................................……………………………………………..

Signature  Signature

...../ ...../ ........              ...../ ...../ ..........

Date  Date
Appendix L Information for women

The Perinatal Journey:
The Process, Impact and Outcomes of
Psychosocial Assessment

INFORMATION FOR WOMEN

Introduction
You are invited to take part in a research study into the process and impact of the psychosocial assessment; this assessment is undertaken by midwives during the antenatal booking visit and by child and family health nurses (CFHN) in the postnatal universal home visit. We want to explore how nature of the assessment influences women and families to engage in ongoing services. The study also, aims to determine the relationship between social and emotional health in pregnancy and after birth, and the use of health services and outcomes for women and their infants at 6 weeks and 6 months after birth.

In NSW it is routine to ask all women before and after birth about their social and emotional wellbeing. The purpose of this study is to see if there is a link between any potential concerns or needs identified by the midwife or CFHN such as difficulties with your living situation or a change in your emotional or mental wellbeing and if you choose to use services or supports offered by the midwife or CFHN. We are also interested in your experience of being asked these routine questions related to social and emotional wellbeing and we are interested in observing the approach that the midwives or CFHN’s use when asking you these questions.

The study is being conducted within this institution by Associate Professor Virginia Schmied (University of Western Sydney), Dr Lynn Kemp (University of New South Wales), Dr Tanya Covic (University of Western Sydney) and PhD candidate Mellanie Rollans (University of Western Sydney). The study is part of a collaborative study in with partnership Karitane a child and family care service in NSW. The study is being sponsored by the Australian Research Council Linkage Project and the University of Western Sydney.

Study Procedures
If you agree to participate in this study, you will be asked to sign the Participant Consent Form. You will then be asked to undergo the following procedures:

1. The researcher will ask permission to observe the initial consultation you have with a midwife at the Antenatal clinic. They will be observing the interactions between the midwife and yourself and the approaches the midwife takes when talking with you and asking you questions.

2. A follow-up phone call will be made to you approximately one week after your visit with the midwife to confirm arrangements for the first interview.
3. When you return for your next appointment at the Antenatal clinic, the researcher will meet with you to undertake an interview which involves a survey and also some open-ended questions. These will ask about your experience or perceptions of the assessment process and whether you followed up on any services that may have been offered/suggested to you. This interview will take approximately 30 to 40 minutes and will be scheduled to fit with your antenatal appointment.

4. Approximately 4 weeks before your baby is born the researcher will ring you to ask if you are still happy to participate in the study and will ask you briefly about what services you have been using in pregnancy.

5. After the expected date of delivery of your baby the researcher will contact you and ask about the birth. If your baby needs prolonged additional care in hospital, or is not in your care after you come home from hospital, you will be given the option of continuing to meet with the researcher or withdrawing from the study.

6. With your permission the researcher may observe the initial visit with the child and family health nurse after your baby is born to observe the interactions between the child and family health nurse and yourself and the approaches the child and family health nurse takes when talking with you and asking you questions.

7. A follow-up phone call will be made to you approximately one week after your visit with the child and family health nurse to confirm arrangements for the second interview.

8. When your baby is about 6 to 8 weeks old the researcher will meet with you to conduct the second interview. This interview will include open-ended questions seeking information on your experience or perceptions of the assessment process and whether you sought supports offered to you. You will also be asked to complete a survey about your emotional wellbeing and you or your baby’s health. This will be in a place that is convenient to you and will take approximately 30-40 minutes.

9. The final interview will be when your baby is 6 months old which will again includes both open-ended questions and a brief survey. This will seek information about your emotional wellbeing and you or your baby’s health. This will be in a place that is convenient to you and will take approximately 30-40 minutes.

**Risks**

This study involves observing the interactions between you and the midwife or child and family health nurse and it is not expected that this should cause you any discomfort. If you are uncomfortable being observed remember that participation in this study is completely voluntary and you can withdraw at any time without any consequences. At the end of the observation period the researcher will leave the room giving you an opportunity for separate time with the midwife or child and family health nurse.

The known risk of this study is the possibility of psychological discomfort when relating the story of your experience to the researcher. The potential severity and duration of the discomfort is unknown, and may be minor. If you experience any discomfort, a referral will be suggested for counselling through your local community health centre.

**Benefits**

While we intend that this research study will improve midwifery and child and family health services and ultimately improve other women’s experience of care during the perinatal period in the future, it may not be of direct benefit to you.
Costs

Participation in this study will not cost you anything. In recognition of your time, a Coles Gift Voucher will be provided after the first and third interviews with the researcher (voucher to the value of $25).

Voluntary Participation

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason. Whatever your decision, please be assured that it will not affect your medical treatment or your relationship with the staff who are caring for you. Of the people treating you, only those named above, your midwife and your child and family health nurse will be aware of your participation or non-participation.

Confidentiality

All the information collected from you for the study will be treated confidentially, and only the researchers named above will have access to it. The study results may be presented at a conference or in a scientific publication, but individual participants will not be identifiable in such a presentation.

Further Information

When you have read this information, Mellanie Rollans will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact her on 0437 864 232.

This information sheet is for you to keep.

Ethics Approval and Complaints

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney South West Area Health Service. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number X??-0???.

The conduct of this study at the Royal Hospital for Women has been authorised by Sydney South West Area Health Service. The conduct of this study at the Liverpool Hospital has been authorised by South Eastern Sydney Illawarra Area Health Service. Any person with concerns or complaints about the conduct of this study may also contact the Research Governance Officer [or other officer] on [telephone number] and quote protocol number [insert local protocol number].

Thank you for considering this invitation

Signatures

A/Prof Virginia Schmied Ms Mellanie Rollans
University of Western Sydney University of Western Sydney

................................................... …………………………………………….

Signature  Signature

...../ ...../ ..........    ...../ ...../ ..........

Date  Date
Appendix M Ethics Approval

3 May 2010

A/Professor V Schmied
University of Western Sydney
Parramatta Campus
Locked Bag 1797
PENRITH SOUTH DC NSW 1797

Dear Professor Schmied,

Re: Protocol No X10-0064 & HREC/10/RPAH/118 - “The perinatal journey: The process, impact and outcomes of psychosocial assessment”

The Executive of the Ethics Review Committee, at its meeting of 20 April 2010, agreed with your correspondence (received 28 April 2010) in accordance with the decision made by the Ethics Review Committee, at its meeting of 10 February 2010, ethical approval is now granted.

This approval includes the following:

- Protocol (Version 2, 28 April 2010)
- Cover Letter (Master Version 2, 28 April 2010)
- Expression of Interest (Version 1, 28 April 2010)
- Flyer Advertisement (Version 2, 28 April 2010)
- Information for Women (Master Version 3, 28 April 2010)
- Consent Form for Participating Women (Master Version 1, 17 February 2010)
• Information for Midwives and Child & Family Health Nurses (Master Version 3, 28 April 2010)

• Consent Form for Midwives and Child and Family Health Nurses (CFHN) (Master Version 1, 17 February 2010)

• Observation Tool (Version 1, 24 February 2010)

• Perinatal Journey Survey (Version 1, 24 February 2010)

You are asked to note the following:

• **This letter constitutes ethical approval only. You must NOT commence this research project at ANY site until you have submitted a Site Specific Assessment Form to the Research Governance Officer and received separate authorisation from the Chief Executive or delegate of that site.**

• This approval is valid for four years, and the Committee requires that you furnish it with annual reports on the study’s progress beginning in May 2011.

• This human research ethics committee (HREC) has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review and is constituted and operates in accordance with the National Health and Medical Research Council’s *National Statement on Ethical Conduct in Human Research* and the CPMP/ICH Note for Guidance on Good Clinical Practice.

• You must immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project.

• You must notify the HREC of proposed changes to the research protocol or conduct of the research in the specified format.

• You must notify the HREC and other participating sites, giving reasons, if the project is discontinued at a site before the expected date of completion.

• Where appropriate, the Committee recommends that you consult with your Medical Defence Union to ensure that you are adequately covered for the purposes of conducting this study.

Should you have any queries about the Committee’s consideration of your project, please contact me. The Committee’s Terms of Reference, Standard Operating Procedures, membership and standard forms are available from the Sydney South West Area Health Service website.

_A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer._
### Appendix N Table 2 Reasons women were unable to participate in antenatal interviews, and postnatal observation with CFHNs

<table>
<thead>
<tr>
<th>Reasons women were unable to participate in antenatal interviews, and postnatal observation with CFHNs</th>
<th>Number of participants</th>
<th>Brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withdrew</td>
<td>4</td>
<td>These women withdrew: due to having a premature baby; had other commitments; first baby and wanted to maintain discretion; unable to make contact, therefore, antenatal interviews were not conducted.</td>
</tr>
<tr>
<td>Relocated</td>
<td>5</td>
<td>These women relocated to areas where ethics had not been obtained to perform postnatal observations with CFHNs.</td>
</tr>
<tr>
<td>Coordination issues</td>
<td>2</td>
<td>There were challenges in coordinating visits between participating CFHNs and the time frame allocated for women to have their UHHV within 6 weeks. On one occasion the visit had already occurred but the researcher was not informed; on another occasion the researcher was engaged in observing interactions with other women.</td>
</tr>
<tr>
<td>Attendance issues</td>
<td>2</td>
<td>On one occasion the father attended with the baby to the CFHNs visit and the second participant, the mother did not attend booked appointment visit in clinic.</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>One woman declined a home visit due to her experience with health professionals in the antenatal period</td>
</tr>
</tbody>
</table>