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Midwives' descriptions of strategies and requirements when following up pregnant women at risk of developing perinatal depression - a qualitative study

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ABSTRACT

Introduction: According to the guidelines, health-care personnel should have routines to identify depression and anxiety, but no screening tool is required. The aim of the study is to describe how midwives in antenatal care describe strategies and requirements when following up pregnant women at risk of developing perinatal depression.

Methods: Study is designed as qualitative descriptive study. It includes authorized midwives who work in prenatal care in Western Norway (n = 11) were interviewed between October 21 and November 02, 2021. Verbatim transcribed interviews were analyzed using manifest qualitative content analysis. The study was performed in accordance with the Consolidated Criteria for Reporting Qualitative Research.

Results: The manifest content analysis revealed three categories: (1) Midwife as haven, (2) Growing into the professional role as a midwife and (3) Organizational challenges in antenatal care. The midwives also expressed that they felt they were saddled with a great responsibility that could be a lot to bear. Clinical experience was highlighted as essential sources of self-confidence in work.

Conclusion: Identified categories confirm some crucial issues in midwifery-led maternity care, such as the need for continuous professional training, clear local guidelines, and sufficient time for consultation with women at risk of developing perinatal depression. The findings also reflect the importance of early detection of these women to offer support and assistance throughout pregnancy and after delivery.

Keywords: perinatal depression; prenatal care; midwife; midwifery professional education; qualitative research

INTRODUCTION

Perinatal depression is a severe complication as, without treatment, it can negatively affect both the mother's and child's health (1). It is estimated that about 13% of pregnant women each year develop a mental illness during pregnancy or after childbirth (2,3). A previous history of depression, poor relationships, lack of social network, financial challenges, violence, stress, and substance abuse are some of the potential risk factors for developing perinatal depression (4,5) Further, a connection has been found between perinatal depression and premature birth, low birth weight, and intrauterine slow fetal growth (6). Pregnant women with depression have a significantly higher probability of developing postpartum depression compared to women who have no symptoms of depression during pregnancy (7). Yazici et al. found that up to 92% of women with untreated depression in pregnancy developed postpartum depression, compared to those who received treatment for their depression (8). Given such a high risk for pregnant women with undiagnosed or untreated depression, studies from Fletcher et al. (9) and Higgins et al. (10) highlight that midwives in antenatal care lack training and experience in mental health during pregnancy. The same need for knowledge is also demonstrated by midwifery students, as the subject of mental illness during pregnancy does not occupy a prominent place in the midwifery curriculum (11,12). Furthermore, recent research shows a significant increase in mental illness among pregnant women during the pandemic caused by Covid-19 and prolonged isolation with minimal face-to-face contact with their midwives (13,14).

In Norway, midwifery training is a 2-year specialization at the master's level (120 ECTS credits) (15) after a bachelor's degree in nursing and at least 1 year of work experience as a nurse. Non-complicated antenatal care, childbirth, and postnatal care, including reproductive health, are the responsibility of authorized midwives or general practitioners (GPs) (15). Antenatal care is part of the health and care service in all municipalities, and health personnel

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who carry out pregnancy controls must follow the national professional guidelines (15-17). It is recommended that pregnant women be offered a basic program of nine consultations, including fetal diagnostics. The offer is free, and women choose whether they want to go to a midwife or a GP. Pregnant women with an immigrant background have the right to an interpreter if their knowledge of Norwegian is limited. According to the guidelines, health-care personnel should have routines to identify depression and anxiety, but no screening tool is required (17,18).

The aim of the study is to get insight into how midwives in antenatal care describe strategies and requirements when following up pregnant women at risk of developing antenatal depression.

METHODS

This study was conducted following the Consolidated Criteria for Reporting Qualitative Research (19) and had a qualitative design with a hermeneutic approach (20). Data were collected using qualitative semi-structured interviews (21).

The inclusion criteria for participating in the study were that the midwife had to have a Norwegian authorization, at least 1 year's experience in maternity care, and at least 50% employment. Information letters and informed consent forms were sent to the managers at two large health centers in Western Norway, who forwarded the information and informed consent forms to 30 midwives. Midwives interested in participating in the study contacted the co-authors to arrange a time and place for an interview. Eleven midwives showed their interest, and nine carried out interviews. All were women. They had been working as midwives for between 5 and 35 years and had worked explicitly in maternity care for between 2.5 and 20 years. Three midwives had advanced training in mental health.

The interviews were conducted by BF and KVF between October 21 and November 02, 2021 at the midwives' workplace. The interview guide was checked by the supervisor and co-author (ZP). First, the pilot interview was conducted to check the interview questions and interviewers' interview techniques. We considered that the pilot interview was of good quality, and we included this interview in the study. We conducted the interviews together, alternating roles as interviewer and observer taking notes during interviews. The interviews lasted between 30 and 82 min. All interviews were recorded on a Dictaphone, and field notes were also taken to capture the mood and events that did not make it onto the audio tape. We transcribed all audio files verbatim (BF and KVF). After the seventh interview, we got the impression that nothing new was coming up, but we chose to carry out two more interviews, partly because we wanted to confirm our initial impression and partly, from an ethical point of view, to go through with interviews with all those who agreed to participate.

The study has been reviewed and approved by the Norwegian Center for Research Data (NSD), ref. nr. 154300. Both oral and written informed consent was obtained from the midwives prior to the interviews. Participation in the interview was voluntary, and the midwives could withdraw at any time without any explanation or consequences for them. During the transcription, the text was anonymized. Quotations are presented from the various midwives under fictitious names.

Graneheim and Lundman's manifest qualitative content analysis was used in the analysis process (22). All authors were involved in all steps of the analysis, and all steps were discussed between co-authors, master's student colleagues and senior lecturers at the master's seminars to avoid naïve and subjective interpretations. The analysis was performed in the following steps: First, we read transcripts several times to grasp what they were about. Second, we extracted meaning units and condensed them. Third, we coded condensates and grouped codes (Table 1) into subcategories. Finally, we grouped subcategories into three categories (1) Midwife as haven, (2) Growing into the professional role as a midwife, and (3) Organizational challenges in antenatal care (Table 2).

RESULTS

Our analysis showed that the midwives used different strategies based mainly on their clinical experience or clinical intuition when caring for pregnant women at risk of developing perinatal depression. Several midwives emphasized that growth in their professional role was essential to improving their professional skills to meet this patient group. Another aspect that clearly emerged was challenges related to how their work is organized, how many times they can meet patients, and how much time they can spend on each pregnant woman in maternity care. All midwives expressed that the time they get for pregnancy checks is insufficient to identify the risk of antenatal depression.

The midwives highlighted the need to find strategies for getting close to the women in prenatal care and building trust to establish relationships with them. Much was said about the importance of gaining women's trust early on so that they felt safe coming to the midwife. This laid the foundation for whether it was possible detect a risk of perinatal depression early.

The theme of building trust and relationships with women resonated with all the midwives. Establishing a relationship was an important strategy. The first meeting with a woman laid the foundation for how subsequent consultations went. Personal chemistry was essential. Midwife consultations were assumed to be a haven and it was essential to signal that there was plenty of time to talk, and that it was okay to talk about everything. For the midwives, it was important to be available to their patients: women should have time to talk, be followed up and be recognized. One of the midwives, "Ingrid," expressed it this way:

You must build up a bit of trust in relationships then, so if you are a person they want to open up to; I think mostly they are … I tend to say that if I had been paid for the number of tears in my office, I would have been super *rich. Because of many struggles, mental health is often* the neglected child of *the system.*

One midwife said she was surprised by how open some pregnant women could be when she started perinatal care. She experienced that some pregnant women immediately trusted their midwife. One of the crucial strategies highlighted was to be conversation partners, to show sincere interest, listen actively and strive to create a trusting

TABLE 1. Example - Meaning units, condensed meaning units, and codes

Meaning units	Condensed meaning units	Codes
I think that it is always possible to get better, but that I can always benefit from my years, that is, the many years of work as a midwife, and from life experience, which I have in a way taken with me, which means that I have a, a little different understanding, more humility... more... yes, [I] see things a little differently than I did at the start (Martha)	It is always possible to get better, but I have taken with my life experience, and I have a different understanding and more humility now than at the start	Life experience
..and I think that we as midwives, with the education we have, should have enough authority to tolerate people rejecting us and preferring to go to our colleague (Victoria)	We as midwives should have enough authority to tolerate being rejected and that they would rather go to our colleague	Authority
I'm not afraid to ask about things. I think I am quite brave. It's because I have such a basic sense of security in myself that I can ask about things. And it hasn't always been like that. When I was a new graduate there was a lot that was scary (Emilie)	I think I'm brave, and not too afraid to ask. I have a basic sense of security in myself, but when I was a new graduate, a lot was scary.	Brave
So, it's therapy just you put words to things and get it out. I think it's just a relief that she doesn't have to keep the mask on with me then. Hmm. If there is something to it, we can't do much about it, but we can at least listen, and that shouldn't be underestimated. Being a shoulder [to cry on] and an ear, many times it's magical. We must... we are programmed in the healthcare system to fix everything and come up with solutions, but you don't have to... always (Ingrid)	It is a therapy and a relief to be able to put things into words and to be able to vent, not having to hold the mask. We shouldn't underestimate listening, we don't always have to fix everything and come up with solutions.	Active listening
...but it's quite sad to hear "I was depressed, but no one knew it." But that and then give them room to be able to talk about it. Yes. Don't be in a rush; even if you're short on time, you must never show that you don't have much time! (Olivia)	It's sad to hear that they were depressed last time without anyone knowing. Give them room to talk about it. You must never give the impression that you don't have time.	Have time
Eh, I feel like I can help a little, but if it gets too advanced and stuff like that, I feel like I'm on shaky ground, in a way. (Lilly)	I feel I can help a little, but if it gets too advanced, I feel like I'm on shaky ground.	Not sure

TABLE 2. Overview of subcategories and categories

Subcategory	Category
The art of creating trust	Midwife as haven
Detecting risk	
Wanting to see the whole woman	Growing into the professional role as a midwife
Midwives' specific measures	
Midwife as expert	
Development of midwives' competence	Organizational challenges in antenatal care
Continuity throughout pregnancy care	
Burden on midwives	

relationship and good contact. The trusting relationship then improved, making it easier for the women to tell how they felt, and midwives had more opportunities to plan more careful follow-ups. Most of the midwives observed that many pregnant women were grateful to be asked about their psychological health. They noted that most pregnant women were very open to sharing how they actually felt. The midwives felt it was a relief for most of their patients to have a person they could confide in about how they felt.

The midwives were concerned with the continuity of work; it was vital for them to follow up with women themselves. This created the best dialogue and allowed women to feel that the appointment was a time to focus on them. One midwife was clear that if she was ill one day, she wanted the woman to return to her the following week instead of going to another midwife on the same day. Another midwife stated that she would sometimes send a pregnant woman to a colleague for an additional assessment if she felt that her competence was insufficient or needed to discuss the case or have her observations confirmed. All the midwives agreed that home visits and 6-week check-ups would provide the optimal follow-up.

All midwives agreed that psychological illness is more common these days than a few years ago. They explained that nearly one out of every three pregnant women they related had some type of psychological diagnosis that is already medicated when enrolling in maternity care. One midwife pointed out that the growing trend of body image pressure from the media and high demands on the pregnancy itself could contribute to feelings of shame with decreased self-awareness. The midwives describe that all these stressors can have a negative impact on mental health, especially in those at risk of developing antenatal depression. Some midwives assumed that antenatal depression is probably underdiagnosed and that many cases are most likely not discovered until later in pregnancy. Many found it difficult to differentiate between normal psychological health during pregnancy ailments and depression. "Ingrid" expressed it in this way:

It is difficult to say precisely where the line is because life is painful for most people.… but if it goes beyond everyday function or sleep or joy and if everything goes black and you can't see anything, if there is nothing that gives you joy, then you can think that now you are pretty much stuck in something dark.

Several respondents mentioned that many physiological changes occur in the body and brain during pregnancy. Therefore, it is normal to have mood swings and experience inner turmoil when pregnant. None of the midwives had ever witnessed a woman being diagnosed with antenatal depression by a GP or psychologist during a pregnancy. Some women had depression going into pregnancy, and others said they had most likely been depressed in their previous pregnancies. One midwife expressed uncertainty as to whether a diagnosis had actually been made. Several midwives said they sometimes failed to ask because many pregnant women do not give any visible impression that

their mental health is worse than before. Several midwives noted that while there is more openness around psychological health nowadays, it is still regarded as taboo and stigma remains, with "Katrine," for example, remarking that "*it's often more difficult for people to open up about mental illness compared to the fact that they have diabetes*."

To detect psychological challenges, a midwife must be confident in her own role, have knowledge of the topic and want to see the whole woman being treated. Midwives must give of themselves and be able to individualize so that each individual woman is seen.

Several of the midwives said they were direct and fearless when it came to talking about mental health. The midwives used different approaches: Some asked direct questions while others asked more open, wondering questions, and let the women tell as much as possible themselves. To be able to detect as many cases of antenatal depression as possible, several midwives pointed out that it was important to dare to ask questions. They emphasized the need to be confident in the role of midwife and to have the poise to stand up in difficult situations. One midwife said that one had to dare to be direct even if one risked being rejected, while another believed that one had to be careful so as not to get too close to the women. The midwives explained that by prioritizing the conversation, by looking at and listening to women, it was possible to find new approaches to help. One midwife expressed her belief that it was important to be brave and fearless and not to shy away from meeting women.

Several midwives also mentioned empathy, including "Emilie," who explained that to allow women to open up it was important to ask "*direct questions. [To] be honest. And in a way… compassionate, true, [to use an] empathetic approach… dare to be honest,* [to] *say* "*I see that you are not well."*

Engagement, curiosity, and a welcoming attitude were highlighted as important qualities. You had to signal that you wanted to hear what they had to say, and that you had time to accept what came. Simple things like how to sit in the chair were important. The midwives also felt that being prepared for the answers they received was important for how the women interpreted their genuine interest in helping further.

Several of the midwives were knowledgeable about motivational interviewing and consciously used this approach in their consultations. Some used the pregnancy health card as a starting point for the conversation, while others deliberately tried to have a more fluid conversation, so that it would not be perceived as a checklist. Most tried to normalize mental health, to make it harmless and to mention it in the same way as other physical ailments and diseases. Almost all the midwives stated that they asked how their patients were doing at each consultation. In contrast, there was one midwife who was clear that she did not ask every time, as it was not written as a separate item on the health card, and that it could be difficult to remember. It sometimes became problematic when challenges came up at the end of the consultation, and several midwives said it hurt to have to stop and say they had to follow-up later because the time was up. One midwife said she brought up the topic of mental health early in the consultation, in case something came up:

I ask about it first… and if they have a lot to say, then I just leave everything else alone, then we just talk about it... and I definitely do that because I've worked here for so long that I know that there is nothing burning. ("Emilie")

None of the midwives used screening tools, such as the Edinburgh Postnatal Depression Scale (EPDS), routinely They had EPDS in mind, and were happy to use some of the questions in the consultations. All midwives felt that there was a good opportunity to individualize care. One midwife said:

We don't carry out any diagnostics in that sense, true, but I have a lot of people who come for extra consultations because of mental health, I have a lot of people, yes. I don't really know how many, but I have it every day anyway. So that's quite a lot. ("Victoria")

Standard consultations were 30 min with the possibility of scheduling 60-min consultations if necessary. Several pointed out that 30 min was not long enough to have a good conversation and they felt that the time often limited them in their work. In addition, the women mainly alternated between seeing the midwife and the doctor, which often meant that the midwives did not see women more than four to 5 times during their pregnancy. The midwives were free to set up extra consultations or longer consultations for women who needed it. Sometimes they took control and set up a new appointment quickly while other times they left it up to the woman herself when she wanted to return. All midwives said that if a risk was discovered at the first consultation, they set up a new consultation earlier than what was recommended in the basic program. One midwife deliberately scheduled woman with challenges for the end of the working day so she did not have to worry about running out of time, as doing so would only go beyond her own administrative time. Several of the midwives also pointed out the importance of prioritization, spending little time on those who did not need extra follow-up so that they could spend more time on those who needed it.

The midwives saw the importance of a social network for the pregnant women. Several spent a lot of time surveying the pregnancy network, helping the women to understand where they could get help and support.

The midwives were clear that they grew and became more confident in their role over time as they worked. They reported that with experience it became easier to ask about mental health and to give women further help. Work and life experience was also related to self-confidence, making it easier to know where and how to get help, and how to handle challenging situations. The midwives were able to look at situations differently, with different preconceptions and more humility, and understood the women better as the years went by. Being able to deviate from the script and timetable also became easier as the midwives gained more experience. Several were able to recognize what was important to address immediately and leave the rest for next time.

Several of the midwives placed great emphasis on their own gut feeling, on seeing what was not said and feeling what their patient were actually expressing. By being sensitive to women's cues they were able to more deeply understand what the women were telling them. One midwife believed that the feeling in her gut was not just perception but

something she had acquired through experience and theory over the years. Another felt that her gut feeling perhaps helped her more with the physical than the psychological. One of the midwives said she only used her gut feeling a little and did not dare to use it more than that. Many midwives pointed out that not everyone needed to be referred further by a midwife or to receive a higher level of care. Most of the midwives experienced that if they took the time to care and listen to what women said, they could get very far. Many women just needed someone to vent to, someone who had time to hear what was in their hearts: *'So maybe, maybe by being more active and giving of ourselves like we do, it doesn't turn out as bad as it necessarily could have turned out if they were not seen and heard*' ("Olivia").

Continuing education was important for midwives to feel they could provide good help to the women they saw. Frustration over their lack of referral rights and poor cooperation with GPs created headaches for the midwives. Because the midwives felt a great deal of responsibility for the women's care, they could become insecure.

Three of the midwives had additional training related to mental health. The rest were clear that they wanted more knowledge about the topic, either more courses or further education, but several said that they were limited by finances in the municipality. One expressed that she felt she could only help a little, but if it became too advanced, she felt like she was on shaky ground. She described that she did a lot of searches for education because she had no additional courses or education. Another pointed out the usefulness of having further education: *"So I think we really focus on antenatal depression, but I certainly focus on it more now that I have taken that further education*" ("Sarah").

Being able to consult with colleagues, attend conferences, and share experiences was positive. One midwife explained that working with so many talented colleagues enabled one to grow not only as a midwife, but also as a person. During the interviews, the midwives often answered using the plural "we," even though the questions were about their personal experiences.

They mentioned women who had challenges in their cohabitation and difficult couple relationships as an area they could become more competent in. One midwife, for example, had treated women who experienced a breakup in the middle of pregnancy. She mentioned that it was difficult to know how to handle the grief and problems that arose in that situation.

All the midwives highlighted the challenges of cooperating, and often the lack of cooperation, with GPs. They often sent information to GPs but received nothing back from them. The midwives also emphasized that GPs had 15–20 min with each patient and therefore did not have the opportunity to establish the same relationship as a midwife. The midwives lacked information from the GP when it came to mental health, including what measures had been taken and any referrals. If something had been done, it was the woman herself who informed the midwife afterwards:

So, I wish we had a little more cooperation with [the GPs]. *But many referrals must go through the GP, so they refer [women] to a psychologist, the* district p*sychiatric cent*re *(DPS) and things like that... but that communication, it's often one-way* ("Ingrid").

All the midwives expressed that they found it difficult to get women to see a psychologist. Waiting times were long and there were different levels of aid agencies; some midwives had experienced being told that their patients sounded too sick when they asked for help from certain agencies. The midwives also described that they did not have referral rights, which they found frustrating. Several said it was illogical that only the GP could refer patients to a psychologist and the DPS, when it was often the midwife who knew the pregnant woman best:

And that and the fact that we can't refer you to anyone, not to a psychologist or a psychiatrist or anything, it's a bit frustrating. And... erm, they think that the GP knows them best, but I don't necessarily think that they do, because maybe the first person they've told that to is me! ("Olivia")

One midwife noted that it was difficult in the beginning to navigate between all the help services, including where she could and should refer, but this got better after she had worked for a few years. One municipality had access to a psychiatric nurse who could take part in conversations. The midwives had a very good experience with this. They explained that the nurse brought her tools and listened to the women and was able to categorize their concerns in a different way so that she found out what the case was about. One midwife said that she was glad that there were two of them who were responsible for the woman. All the midwives thought it would be good if they could place the women at risk of developing antenatal depression in a system so that they didn't have to shoulder such a big responsibility alone.

One midwife informed the women she saw that she was "just" a midwife and that there was a limit to what she could help with when it came to mental health. Another midwife was concerned with the distribution of responsibilities and explained that she did not emphasize mental health if the woman was already in the mental health care system. She then focused on the physical aspect of the pregnancy, but still allowed the woman to bring up whatever subject she wanted, even if she was adequately followed by a psychologist.

The midwives used their own record system and noted on the pregnant women's patient record if they were given permission to do so by the woman. They were keen to pass on information about mental health to the birth and maternity department but experienced that some women did not want it to be documented on their pregnancy health record.

All the midwives felt that they had a great responsibility when it came to pregnant women's mental health. The vast majority were sure that they were unable to detect everyone with antenatal depression and this was onerous and painful. Several said that they felt a sense of inadequacy and that they could become discouraged when they saw that they were not able to help as much as they had wanted. They were afraid of misjudging the severity of their patients' condition, as they were unsure whether women gave them honest answers and whether they were able to reach out to them. One midwife, "Nora," admitted *"...well, I think you don't discover everyone, we don't*."

The midwifery service had no routines for getting feedback from the women who had seen a midwife. The women who gave verbal feedback were all satisfied. One midwife was aware of this and said that those with negative feedback were not seen again as they most likely chose not to return to the same midwife in the event of a new pregnancy and instead had their 6-week check-up with the GP. Most of the midwives missed some form of feedback, both good and bad, to know that they did a good job, but also to improve in their own work.

DISCUSSION

The midwives in our study expressed a need for more knowledge about mental health and for sufficient time in the consultations to detect women who were at risk of developing antenatal depression. They also failed to discover everyone who struggled and described that this was a big responsibility to carry alone.

Our results are confirmed by several studies that highlight midwives' desire for more accessible education related to mental health (12,23,24). Carroll et al. (25) found that midwives with some form of additional mental health education showed a statistically significantly higher level of knowledge, self-confidence, and skills compared to those who received no additional education (25). Lack of knowledge and routines have been shown to lead to too many referrals to an already overloaded specialist health service (26,27). Carroll et al. point out that midwives need to know when women should be referred further, or when conversations with midwives are sufficient (25). Lack of knowledge also prevents midwives from addressing the topic of mental health with women (28). Davies et al. and Hauck et al. (11,12) also highlight the fact that midwives and midwifery students do not feel knowledgeable when it comes to mental health in pregnant women. A desire for further education is one thing, but what about basic training for midwives Jarrett (29,30) examined final-year midwifery students' knowledge of mental health in pregnant women and concluded that there was a lack of knowledge about women's risk of developing problems related to mental health. The students were aware of the importance of asking questions about mental health, but they underestimated the risk both in healthy women and in women who had a history of serious mental disorders (29,30). Midwifery students need a better understanding of the complexities of mental health and risk factors for developing problems (29,30). Martin et al. (31,32) claim that the large focus on physical health in midwifery education is detrimental to the level of knowledge and self-confidence needed to deal with women with challenges related to mental health. They point to a possible need to adjust the midwifery education curriculum, which is also supported by Jarrett (29,30), who believes that a review of the current midwifery education is needed. Makunde (33) recommends that education in mental health must be incorporated into midwifery education. Higgins et al. (10,34) developed a 30-h module to improve midwifery students' knowledge and skills in mental health. Investigations after the implementation of the module clearly showed a positive effect. They recommend that other educational institutions also consider the possibility of adopting such modules. Our findings on security and work experience are supported by, among other things, the study by Fontein-Kuipers et al. (35) in which midwives cited work experience as their most important source of knowledge when it came to mental health. This is consistent with Fletcher et al. (9), who also found a clear connection between work experience and midwives' self-confidence, as well as their ability to detect and deal with women with antenatal depression. This is also supported by Ross-Davie et al.'s (36) study which concluded that midwives felt that their education prepared them too little for addressing mental health versus physical health in pregnancy. Fontein-Kuipers et al.'s (35) study also points out that newly qualified midwives have a greater focus on practical skills related to children's and mothers' physical health than on psychological aspects. Midwives are obliged to provide proper healthcare, including staying up-to-date professionally (37). Norwegian midwives are nevertheless not obliged to undergo professional development through specific programs, such as continued professional development, also known as continuing professional education (CPE), which is problematized by Lukasse and Pajalic. Several studies show that younger midwives and midwives with less experience have a higher risk of burnout (38,39). Current measures to keep midwives in the profession are to offer CPE, as well as giving them the opportunity to practice woman-centered care (23,40). Our findings showed that the midwives were clearly limited by time, especially in the form of short consultations, but that there were still good opportunities to schedule longer consultations when necessary. Lack of time is often reported as a problem when it comes to addressing mental health (28). Several studies show that a lack of time can prevent sensitive topics from being addressed (9,10,34) which was also confirmed by the midwives in our study. Higgins et al. suggest that role-playing games and digital tools can be used to develop midwives 'skills in opening up conversations, as it is challenging to bring up sensitive topics in a short time and at the first meeting with a patient (10,34). It is also problematic that not seeing patients often enough can be an obstacle to raising the topic of mental health (10) this was something that was confirmed by the midwives, considering that they often did not meet women that many times during their pregnancy.

Limitations of the study

We tried to be aware of our preconceptions throughout the process. We were halfway through the midwifery study when we carried out the data collection and, we added some of the midwives from before. We shared the role of interviewer, and to avoid conflicts, we only interviewed midwives we did not know from before. The midwives in this study work in relatively large municipalities in Norway. We know that some smaller municipalities have other guidelines regarding, among other things, the length of consultations, as well as the organization of assistance services. It can also be different in different counties and parts of the country. Our findings nevertheless agree with several international studies, so there is reason to believe that they can be transferred to other midwifery services both in Norway and abroad. We found that there was a good spread among the midwives in terms of both work experience and level of education and we obtained a rich data material.

CONCLUSION

To care for pregnant women in antenatal care, midwives must have sufficient knowledge about how to identify risk factors for antenatal depression. Given the serious consequences of undiagnosed and untreated antenatal depression, the curriculum for midwifery education needs to be revised and already trained midwives must be offered courses and continuing education in mental health. It must also be ensured that midwives have enough time for the women they see, and there is much evidence to suggest that the routines should be changed so that mental health is a mandatory topic beyond the first consultation with the midwife.

IMPLICATIONS FOR PRACTICE

We hope that this study helps to shine a light on the importance of mental health in midwifery education and work. It would also have been interesting to study women's experiences from meeting with midwives in prenatal care to hear their version of how they experience quality and time constraints. The study results describe how midwives' professional competence regarding perinatal depression and the organizational structure of maternity care is essential for the early detection of pregnant women at risk of developing depression during pregnancy. The study highlights the midwives' desire for an increased focus on perinatal depression in work-related professional development and midwifery training and the importance of more consultation time in maternity care.

NO PATIENT OR PUBLIC CONTRIBUTION

The study was designed to capture the experiences of midwives of working in one health-care organization. However, it was not conducted using input or suggestions from the public or the patient population served by the organization.

AUTHOR CONTRIBUTIONS

The study was part of BF and KVF's unpublished master's thesis in midwifery. The study was designed by BF and KVF in collaboration with supervisor and co-author ZP. The interview guide was developed by BF, KVF and ZP. The data were collected and transcribed verbatim by BF and KVF. The transcribed interview material was analysed by BF, KVF and ZP. The results were outlined by BF and KVF. ZP supervised all steps of the study. BF, KVF and ZP wrote the report. On behalf of BF and KVP, ZP accepted the role of the corresponding author.

CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

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