Final Report

NAPD: The National Audit of the Detection and Management of Postnatal Depression

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EXECUTIVE SUMMARY

Background

Postnatal depression is conventionally regarded as depressive illness occurring during the first postnatal year and affects between 10% and 15% of women. The Scottish Intercollegiate Guidelines Network (SIGN) published evidence-based guidelines for screening and management of postnatal depression and puerperal psychosis in June 2002 (SIGN 60, 2002). What remains unknown is the extent of the implementation of policy into practice, the administration of Integrated Care Pathways (ICPs) at NHS Board and General Practice (GP) level, and more detailed evidence of clinical practice.

Method

The project comprised 3 phases. Phase 1 - a questionnaire survey of all NHS Boards in Scotland between September 2003 and February 2004 to determine what (written) policies for postnatal depression were in place as at September 2003. Phase 2 – a questionnaire survey of a representative sample of general practices in Scotland between November 2003 and March 2005 to determine the routine procedures in use for managing postnatal depression in general practice primary care teams. Phase 3 – qualitative work involving focus groups and interviews in 3 NHS Board areas with women who had experienced postnatal services and health professionals involved in the care of women during and following pregnancy. Phase 3 work was carried out by the Scottish Centre for Social Research (SCSR), in conjunction with Scottish Practices and Professionals Involved in Research (SPPIRe).

Key Results

All NHS Boards took part in the questionnaire survey in Phase 1. A total of 199 general practices from a representative sample of 273 took part in the questionnaire survey for Phase 2. Recruitment difficulties in Phase 3 resulted in only 18 participants taking part in focus groups and only 8 individual interviews being carried out. As a result, no conclusions can be drawn from the Phase 3 results.

Six NHS Boards stated that they had ‘always’ taken SIGN 60 into account when preparing/reviewing the NHS Board’s written documentation.

Implementation of SIGN 60 recommendations

1. Forty seven per cent of policies and 68% of GP practices had implemented the majority of the recommendations. GP practices were more likely than Boards to have addressed a higher percentage of the recommendations (p<0.05).
2. Most policies did not recommend antenatal assessment of history of depression, but the majority of GP practices assessed this routinely.
3. The majority of policies specified that postnatal depression should be routinely treated when identified during the postnatal period and support offered.
4. Half of the board policies, and almost 40% of practices said that they offered in-patient facilities for mothers diagnosed with postnatal mental health problems to be admitted with their child, although none was in specialised mother and baby units.
5. Seven policies offered guidance on the use of psychotropic medication to treat depression during pregnancy and ten policies on their use whilst breastfeeding.

Implementation of SIGN 60 good practice points

1. Six policies recommended additional antenatal psychological support for women at risk of developing postnatal depression. Almost 80% of practices indicated that this was already offered.
2. Fourteen policies and 130 (68%) practices recommended that the EPDS should be completed 6-8 weeks following delivery (mean=7.1 weeks) followed by a second assessment (mean=18.9 weeks).
3. A quarter of practices offered complementary therapies in the postnatal period.
4. Seven policies advocated postnatal listening visits by health visitors to women believed to be at high-risk of developing postnatal depression and these were available in 90% of practices.
5. The SIGN cut-off on the EPDS of 10 or above for whole population screening was not used by the majority of policies and GP practices. Half the policies recommended routine antenatal use of the EPDS and this was implemented by 52% of practices.
6. In September 2003, six NHS Boards had ICPs in place and a further five intended to develop an ICP during 2004.
7. Most policies recommended sample auditing of case notes, whereas a minority of the GP practices reported that they undertook sample or continual audits.
8. Most policies (88%) indicated that training in postnatal mood disorders was on offer or was under consideration. In GP practices, 26% offered clinical supervision.
9. Eleven policies provided an antenatal ‘risk-factor’ checklist for practices and 53% of practices implemented a checklist.
10. GP practices were significantly more likely to implement antenatal screening for a history of puerperal psychosis if they were within an NHS Board that recommended it. When the NHS Board policy was in line with the SIGN recommended times the GP practices in the area were more likely to undertake the EPDS assessment within this time frame.

Conclusions

1. Minimum standards represented by SIGN 60 evidence-based recommendations were mostly followed in both policy and practice.
2. If NHS Board policy followed guidelines, the guidelines were more likely to be implemented at general practice level. Overall, practices were more likely to follow SIGN guidelines than were Boards, but they also demonstrated procedures which went beyond those recommended by SIGN.
3. About half of Boards recommended, and general practices used, the EPDS antenatal although this is not recommended by SIGN and is not supported by an evidence base and is therefore a cause for concern.
4. Areas of practice where SIGN guidance was not adhered to included availability of psychosocial interventions, and some antenatal use and cut-off of the EPDS.
Key recommendations

1. SIGN should consider the influences of their guidelines on policy as well as on clinical practice.
2. In many instances GP practices were ahead of NHS Board policies in following recommendations and so could be targeted by SIGN to effect more rapid change.
3. Future work should have two aims. Firstly, to update the findings by repeating the current study and secondly, to include an examination of the experiences and outcomes of care received, rather than solely focusing on the process of care.
1. INTRODUCTION

Postnatal depression is conventionally regarded as depressive illness occurring during the first postnatal year. Between 10% and 15% of women will suffer postnatal depression following childbirth (O’Hara et al, 1996) although there are variations related to culture and deprivation. In a significant proportion of women the illness may have its onset in the antenatal period (Andersson et al, 2003, Evans et al, 2001). Since the first significant study in Edinburgh (Cox et al, 1982) there has been no major epidemiological research into postnatal depression in Scotland, although there is now increased public awareness. The two latest reports on the confidential enquiry into maternal deaths have highlighted the importance of the significant contribution of psychiatric morbidity (Department of Health, 2001; 2004).

In 1987 the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al, 1987) was introduced as a screening tool for detecting women who may be vulnerable to postnatal depression. In the UK the EPDS remains the dominant tool for screening and detection of postnatal depression, although there continues to be discussion around its optimum timing, cut-off scores and relevance to women from other cultures (Elliot et al, 2000; Working Group on Outcome Indicators, 1998). Effective detection and adequate management for postnatal depression requires co-ordination of a wide variety of primary and secondary care services. The co-ordination of these key professionals is complex and management of postnatal depression has been addressed in a variety of ways by SEHD policy and NHS Boards, including the development of Integrated Care Pathways (ICPs).

In 1996 the CRAG working group on maternity services published recommendations on the detection and early intervention in postnatal depression (CRAG, 1996). Their report raised awareness of the issues but was not evidence-based. It recommended the administration of the EPDS at 6-8 weeks postpartum with counselling by trained health visitors, but the recommendations were not implemented routinely across Scotland, resulting in a situation of uneven application (SPCRH, 1999). In 1999 a Management Executive Letter (Services for Women with Postnatal Depression) (MEL 27, 1999) recommended increasing the application of the EPDS to twice postnatally, at 6 weeks and 3 months postpartum, and placed its use into the wider structure of the ICP. The MEL was followed by an increase in the use of the EPDS as a screening tool. However there remained wide variation in its use by health visitors including the timing and the cut-off score. There is also variation in the access to services for women who may have postnatal depression.

Over the last few years the issue of postnatal depression has moved up the health agenda within the UK. Concerns about identification and management of postnatal depression have been noted in several recent reports including the Clinical Outcome Indicators Report (2000). ‘Our National Health: a plan for action a plan for change’ (2001) stated that each local NHS Board will have systems to promote early detection, referral and treatment of postnatal depression. The Framework for Maternity Services (Scottish Executive, 2001a) Principle 17 stated that "There should be a comprehensive, multi-professional, multi-agency service for women who have, or are at risk of, postnatal depression and other mental illness".
The Nursing for Health Review (Scottish Executive, 2001b) specifically highlighted the use of ICPs for postnatal depression as an example of more effective joint working arrangements between primary care and mental health services. It suggested that LHCCs and primary care trusts should explore the effectiveness of perinatal ICPs further and apply them to other areas of mental health. The SEHD Mental Health and Well Being Support Group (Mental Health and Well Being Support Group, 2001) had selected postnatal depression services for a thematic review. They have already collected data on policy from NHS Boards across Scotland and are in the process of continuing data collection.

It is clear that there has been a significant body of work at policy level that is relevant to this project. What remains unknown is the extent of the implementation of policy into practice, detailed information about the administration of ICPs at NHS Board and general practice (GP) level and more detailed evidence of clinical practice. The literature offers a range of anecdotal evidence from staff administering the EPDS (Tully et al, 1998) and some discussion of practice implementation of the EPDS. However, the examples are predominately from England where the organisation of services is different. Thus this project builds on existing work and will extend our understanding of postnatal services.

The Scottish Intercollegiate Guidelines Network (SIGN) published evidence-based guidelines for screening and management of postnatal depression in June 2002 (SIGN 60, 2002). Although postnatal depression and its management has been addressed at policy level it is not known to what extent NHS Board policy and general practice activity has followed these recommendations, and there has been some debate about the effectiveness of guidelines in general.

Health visitors keenly awaited the findings of SIGN 60 and the dissemination events were well attended. Health visitors offer a universal service to all new mothers and are the profession most likely to deal with postnatal depression in the first line. Many of their clients with mild depression never come into contact with any other profession at this time.

The study was set up nationally across Scotland, and all NHS Boards took part in Phase 1. The general practices were recruited across Scotland so that they were representative of NHS Boards, deprivation, urban/rural and Local Health Care Cooperatives. The project was carried out at a time of changing policies and activity in the area of mental health and it is important to recognise that the findings of this study should be set into that fluid context. The context changed with an amendment to the (Care & Treatment) (Scotland) Act 2005 stating that by October 2005 all NHS Board areas must provide appropriate in-patient services for joint mother-infant admissions to hospital. This subsequently led to the development of recommendations around minimum standards of service provision from primary care through to tertiary care services, addressing the prevention, detection and management of mental illness during pregnancy and the postnatal period (SEHD HDL 2004 6). This has strengthened the impetus of policy and service development by NHS Boards during the period the audit has been carried out.
2. AIMS AND OBJECTIVES

This project was carried out to investigate current policy and practice relating to the
detection and management of postnatal depression across Scotland.
Consideration was also given to how effectively the SIGN guidelines have been
incorporated into this process.

The aims and objectives were as follows:

1. To establish the minimum standard for ICPs in identifying and managing
   postnatal depression based on the SIGN guidelines.
2. To carry out a survey of current "front-line" practice in identifying and
   treating postnatal depression across Scotland, and to audit this against the
   minimum standard.
3. To identify, and to report back on, best practice.

Minimum Standards Definition

The initial proposal to NHS QIS indicated that the National Audit of Postnatal
Depression project (NAPD) would identify minimum standards for ICPs based on
the SIGN 60 Guidelines and survey practice by auditing it against the minimum
standards. The minimum standards were taken as the evidence-based
recommendations graded ‘A’ to ‘D’ from the SIGN 60 Guidelines. The questions in
both questionnaires related to the SIGN recommendations. This offers a clear
picture of practice in Scotland at a policy and practice level in relation to the
identified minimum standards.

Over and above the SIGN evidence-based recommendations, the project aimed to
draw a clear picture of routine practice in Scotland in relation to all aspects of the
detection and management of perinatal mental ill-health. ‘Best practice’ was taken
as being evidence-based and, therefore, in identifying areas of ‘best practice’ it
was essential to identify the areas in which health professionals have addressed
the SIGN evidence-base and incorporated good practice recommendations into
routine practice. This report also considers discrepancies in standards of care in
Scotland and additional routine practice that would benefit from audit and research
to determine its validity.

3. METHOD

3.1 Phase 1 – NHS Board Policies

The initial phase of the project was a questionnaire survey of NHS Boards
considering the policy for postnatal depression of each NHS Board in Scotland. All
15 NHS Boards were contacted and asked to send in a copy of their existing
postnatal mental health policy or Integrated Care Pathway (ICP). This allowed the
project team to identify variations in policy and to ensure that all aspects of the
policies were covered in the resultant questionnaire. The final questionnaire
consisted of 139 questions and was based on previous literature, the SIGN
guidelines and the written material provided by all 15 NHS Boards. The questionnaire was sent to representatives of the NHS Boards asking very detailed questions about written policy in place in September 2003. By February 2004 all 15 Boards had responded. At the time, Lothian NHS Board had individual policies within 3 different geographical areas, giving 17 responses in total. As responses differed between these 3 areas, Lothian policies (3) and their practices (22) were excluded from the statistical comparisons of practice and policy.

SIGN recommendations and good practice points are listed in appendix 11.4.

3.2 Phase 2 – General Practice

The purpose of Phase 2 was to audit the routine procedures used for managing postnatal depression in a sample of general practice primary care teams. As this work was part of an audit the project team were advised by MREC (Multi-Centre Research Ethics Committee for Scotland) in August 2004 that ethical approval for this section of the project was not required. A postal questionnaire was developed which contained 64 questions that mirrored those addressed in the Board questionnaire but excluded questions specifically related to Board issues.

A list of general practices in Scotland \((N = 1056)\) was obtained from Information Services of NHS National Services Scotland. In order to ensure that the practices were representative of all practices in Scotland they were initially organised by NHS Board, the percentage of patients with a Jarman deprivation score greater than thirty (Jarman, 1984), urban/rural categories, and Local Health Care Co-operative (LHCC) membership. For the majority of NHS Boards a 25% sample was selected and in the four smallest Boards a larger sample of 33% was selected. Two hundred and seventy-three general practices were identified and asked to complete the questionnaire.

Over a thirteen-month period (September 2004 to October 2005), practices that had failed to return the questionnaire were sent reminders by post and contacted by telephone to optimise the response rates. Initially these reminders were sent to the practice managers. However, following several months of active recruitment the health visitors associated with the practices were contacted and the response rate was improved by this direct contact (Figure 3.2.1).

![Figure 3.2.1: Recruitment of Practices](image-url)
3.3 Phase 3 – Qualitative Aspects

The third phase explored the views of service users and health professionals and was designed to offer greater insight into the processes involved in the detection and management of postnatal depression. This qualitative phase was carried out by the Scottish Centre for Social Research (SCSR). Ethical approval, through the Multicentre Research Ethics Committee (MREC), was gained in July 2004. The SCSR worked in conjunction with Scottish Practices and Professionals Involved in Research (SPPiRe) in order to gain access to the required participants. It was initially anticipated that this phase of the project would last eight months. However, a number of difficulties were faced both in gaining access to practices and in recruitment of women, and as a result the overall contract period was 12 months.

The aim was to carry out focus groups and interviews in three NHS Board areas with women who had experienced postnatal services and health professionals involved in the care of women during and following pregnancy. The areas targeted were Fife, Glasgow and Highland NHS Boards. The sessions were to include focus groups with recent users of maternity services and with health professionals working with recently delivered women, as well as individual interviews with women from ethnic minority groups and with representatives of voluntary sector agencies working with new/vulnerable mothers. The difficulties in recruitment experienced by SCSR resulted in a decision to cease attempts to recruit in June 2005.

4. RESULTS

4.1 SIGN Guidelines in Policy and Practice (Phases 1 & 2)

For the purposes of comparison, the results from the questionnaire survey of NHS Boards (Phase 1) and the questionnaire survey of general practices (Phase 2) are shown together.

All 15 NHS Boards in Scotland contributed to the survey of NHS Board policies for postnatal depression.

For Phase 2, a response rate of 72.9% (n = 199) of the general practices approached was achieved, with a refusal rate of 7% and a no response rate of 20.1%. The representativeness of the participating practices in each NHS Board was confirmed by logistic regression analysis including both categorical (urban/rural scores; NHS Board membership) and continuous (number of GPs in practices; percentage of patients within practice with Jarman scores over 30) variables. No significant differences were found between the participating GP practices and the GP practices that were not included.

4.1.1 NHS Board Policy Development

NHS Boards were asked about the development of policy on management of postnatal depression (PND) in their area. Multi-disciplinary groups were responsible for policy
development in all areas (Table 4.1.1). A named individual was dedicated to the implementation of the SIGN 60 Guidelines in eight NHS Boards and one Lothian Trust.

Table 4.1.1 Professions involved in policy development

<table>
<thead>
<tr>
<th>Profession</th>
<th>N</th>
<th>Profession</th>
<th>N</th>
<th>Profession</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Visitor</td>
<td>14</td>
<td>Social Worker</td>
<td>3</td>
<td>Public Health</td>
<td>2</td>
</tr>
<tr>
<td>Midwife</td>
<td>13</td>
<td>Clinical Psychologist</td>
<td>2</td>
<td>Education</td>
<td>1</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>9</td>
<td>Obstetrician</td>
<td>2</td>
<td>Representative</td>
<td>1</td>
</tr>
<tr>
<td>Nurse Manager</td>
<td>8</td>
<td>Pharmacist</td>
<td>2</td>
<td>PND Project Manager</td>
<td>1</td>
</tr>
<tr>
<td>Community Psychiatric Nurse</td>
<td>7</td>
<td>General Manager</td>
<td>2</td>
<td>Nurse</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>7</td>
<td>Clinical Director</td>
<td>2</td>
<td>Clinical governance</td>
<td>1</td>
</tr>
<tr>
<td>Voluntary Organisation</td>
<td>6</td>
<td>Clinical</td>
<td>2</td>
<td>Mental Health</td>
<td>1</td>
</tr>
<tr>
<td>Service User</td>
<td>5</td>
<td>Health Promotion</td>
<td>2</td>
<td>Manager</td>
<td></td>
</tr>
</tbody>
</table>

Six NHS Boards stated that they had ‘always’ taken the SIGN 60 Guidelines into account when preparing/reviewing the NHS Board’s written documentation. Two NHS Boards had considered the SIGN 60 Guidelines but a further six and the three Lothian Trusts indicated that the SIGN Guidelines had not been considered at all. This was mainly because the policies had been in place before publication of the SIGN Guidelines in June 2002 and had not been revised subsequently. The NHS Board Health Improvement Plan in thirteen NHS Boards featured the provision of a postnatal depression service. Strategy and service developments within the policy were formally reported to the NHS Board Mental Health Steering Group in ten NHS Boards.

Ten NHS Boards and one Lothian Trust had disseminated their written documentation throughout the NHS Board area for implementation. The other four NHS Boards and two Lothian Trusts either had no policy, or were in various stages of developing and disseminating a policy.

Seven NHS Boards reported that predictions of cost for implementation influenced policy development. The NHS Boards and Lothian Trusts which specified that prediction of costs did not influence development of their policies also said that this was because the costs were relatively low. The focus appeared to be on the integration of the EPDS into practice, the implementation of the SIGN 60 guidelines and staff training. It was also suggested that the policy underpins Early Years work already in place. In seven NHS Boards some additional resources had been provided to implement policy.
4.1.2 Implementation of SIGN 60 Recommendations

NAPD investigated which of the SIGN 60 recommendations were included in NHS Board policies and which were implemented in the GP practices.

All thirteen recommendations were addressed in the NHS Board questionnaire and eleven in the GP practice questionnaire. Two SIGN recommendations, relating to guidance on medication used in pregnancy and specifying if postnatal depression was routinely treated when identified, were excluded from the GP practice questionnaire as it was assumed that these could only result in affirmative responses (Figure 4.1.1)¹.

Forty-seven percent (N = 8) of the policies had implemented 7 or more of the 13 SIGN recommendations and 68% (N = 135) of the GP practices had implemented 6 or more of the 11 relevant SIGN recommendations. GP practices were more likely than NHS Boards to have addressed a higher percentage of the recommendations (p<0.05).

A comparison of the responses from NHS Boards and GP practices to the SIGN 60 graded recommendations is shown in Table 4.1.2.

**Diagnosis, screening and prevention**

Most policies did not recommend antenatal assessment of previous history of depression, but the majority of GP practices undertook this assessment routinely. Most policies did not recommend that women be screened antenatally for previous puerperal psychosis, history of psychopathology or family members with history of affective psychosis. However, many GP practices reported routinely enquiring about puerperal psychosis and a history of psychopathology, although a smaller percentage asked about a family history of affective psychosis.

¹ The responses are taken from questions 49F7, 49F8, 49F11, 49F17, 77, 94, 97, 120, 121, 123, 128, 138 and 139 in the questionnaire to NHS Boards (Appendix 11.1) and from questions 10F7, 10F8, 10F11, 10F17, 33, 38, 53A, 53B, 53F, 53G, 54A and 57 in the questionnaire to general practices (Appendix 11.2).
**Management**

The majority of policies specified that postnatal depression should be routinely treated when identified. Puerperal psychosis was not included in this question and in other questions where patient care was unlikely to be managed in primary care.

**Mother and baby units**

Half of the policies reported that they offered in-patient facilities for mothers diagnosed with postnatal mental health problems to be admitted with their child, although none was in specialised mother and baby units. Thirty-nine per cent of the GP practices said that their patients could be admitted to hospital along with their baby to receive psychiatric treatment.

**Prescribing**

Seven policies offered guidance on the use of psychotropic medication to treat depression during pregnancy. This question was not included in the practice questionnaire. Ten policies offered guidance on the use of psychotropic medication to treat depression whilst breastfeeding. Ninety per cent of GP practices stated that breastfeeding status would influence treatment selection.

4.1.3 **Implementation of SIGN 60 ‘Good Practice Points’**

A comparison of the responses from NHS Boards and GP practices to the SIGN 60 Good Practice Points is shown in Table 4.1.3
Table 4.1.2: Comparison of responses of NHS Boards and GP practices to SIGN 60 Recommendations

<table>
<thead>
<tr>
<th>SIGN 60 Recommendation</th>
<th>Policy</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>n (% of N)</td>
</tr>
<tr>
<td><strong>Diagnosis, Screening and Prevention</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Antenatal assessment - history of depression</td>
<td>17</td>
<td>4 (24%)</td>
</tr>
<tr>
<td>C EPDS used as screening tool for PND</td>
<td>16</td>
<td>16 (100%)</td>
</tr>
<tr>
<td>C Clinical evaluation with EPDS recommended</td>
<td>16</td>
<td>11 (69%)</td>
</tr>
<tr>
<td>D Antenatal assessment - history of puerperal psychosis</td>
<td>17</td>
<td>7 (41%)</td>
</tr>
<tr>
<td>D Antenatal assessment - history of psychopathology</td>
<td>17</td>
<td>4 (24%)</td>
</tr>
<tr>
<td>D Antenatal assessment - relative with affective psychosis</td>
<td>17</td>
<td>2 (12%)</td>
</tr>
<tr>
<td><strong>Management</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B PND routinely treated when identified</td>
<td>16</td>
<td>15 (94%)</td>
</tr>
<tr>
<td>B Psychological interventions encouraged for PND</td>
<td>16</td>
<td>8 (50%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Family members routinely offered support for PND</td>
<td>17</td>
<td>4 (24%)</td>
</tr>
<tr>
<td>C Interventions with more than one family at a time</td>
<td>17</td>
<td>8 (47%)</td>
</tr>
<tr>
<td><strong>Mother and baby units</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D In-patient facilities for mother and baby admissions</td>
<td>16</td>
<td>8 (50%)</td>
</tr>
<tr>
<td><strong>Prescribing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Guidance available on medication - pregnancy</td>
<td>17</td>
<td>7 (41%)</td>
</tr>
<tr>
<td>C Guidance available on medication - breastfeeding</td>
<td>16</td>
<td>10 (63%)</td>
</tr>
</tbody>
</table>

*CBT Cognitive behaviour therapy ** Interpersonal Therapy
Table 4.1.3: Comparison of responses of NHS Boards and GP practices to SIGN 60 Good Practice Points

<table>
<thead>
<tr>
<th>Policy</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Antenatal Care**
- Antenatal psychological support for high-risk of PND
  - Policy: 17 (35%)
  - Practice: 189 (79%)
- Antenatal education for high-risk of PND
  - Policy: 17 (6%)
  - Practice: -
- Antenatal psychiatric assessment high-risk of PP
  - Policy: 17 (18%)
  - Practice: -

**Identification of Postnatal Depression and the EPDS**
- 1st assessment EPDS administered 6-8 weeks
  - Policy: 16 (87%)
  - Practice: 190 (68%)
- 2nd assessment EPDS administered 12-16 weeks
  - Policy: 15 (40%)
  - Practice: 153 (55%)
- Health professionals trained in EPDS administration
  - Policy: 17 (71%)
  - Practice: 190 (91%)
- Training - emotional change can be misinterpreted
  - Policy: 17 (59%)
  - Practice: -
- A cut-off on the EPDS of 10 or above
  - Policy: 15 (73%)
  - Practice: 167 (74%)

**Complementary Therapies**
- St John’s Wort discouraged - pregnant
  - Policy: 17 (18%)
  - Practice: 159 (91%)*
- St John’s Wort discouraged - breastfeeding
  - Policy: 16 (19%)
  - Practice: 160 (87%)*
- Complementary therapies discouraged - breastfeeding
  - Policy: 16 (13%)
  - Practice: 166 (73%)*
- Complementary therapies discouraged - pregnant
  - Policy: 17 (6%)
  - Practice: 160 (77%)*

**Management of Postnatal Depression**
- Postnatal listening visits for high-risk of PND
  - Policy: 16 (50%)
  - Practice: 193 (90%)
- Patient offered selection of psychosocial treatments
  - Policy: 17 (29%)
  - Practice: 172 (88%)

**Mother and baby admissions**
- Family involved in mother-baby admissions
  - Policy: 17 (41%)
  - Practice: 173 (87%)
- Multi-professional assessment prior to admission
  - Policy: 17 (35%)
  - Practice: -
- Social work involved in mother-baby admissions
  - Policy: 17 (12%)
  - Practice: 172 (13%)

**Development of ICP**
- ICP in place
  - Policy: 15 (40%)
  - Practice: -
- Of existing ICPs:
  - Representative of professions
    - Policy: 6 (100%)
    - Practice: -
  - In user friendly and succinct form
    - Policy: 6 (100%)
    - Practice: -
  - Relate to local needs
    - Policy: 6 (100%)
    - Practice: -
  - Include documentation
    - Policy: 6 (33%)
    - Practice: -
  - Information on training of staff
    - Policy: 6 (16%)
    - Practice: -

* GP practices were asked about ‘during the postnatal period’ rather than specifically enquiring about breastfeeding mothers
Antenatal care

Only one policy recommended that women considered at high-risk of developing postnatal depression should be routinely offered antenatal education. Six policies recommended additional antenatal psychological support for women at risk of developing postnatal depression. However, almost 80% of practices indicated that this was offered.

Identification of postnatal depression and the EPDS

Fourteen policies and 130 (68%) of the GP practices complied with the SIGN 60 Guidelines in recommending that the first assessment using the EPDS should be completed between 6 and 8 weeks following delivery. The mean time for completion of the first assessment with the EPDS was 7.1 weeks.

Six policies and 84 (55%) of the GP practices had implemented a second assessment in line with SIGN between 12 and 16 weeks following the birth. Seven (5%) of GP practices gave the second assessment before 12 weeks, 22 (14%) between 17 and 24 weeks, 27 (18%) between four and nine months and 3 up to twelve months. Sixty-three practices completed a third assessment at a mean of 31.7 weeks (mode 32 and range 22-48 weeks). Twelve policies recommended that all health professionals that administer the EPDS be trained in its use and 91% (n = 173) of practices allowed only trained staff to administer the EPDS.

The majority of policies and GP practices did not use the SIGN recommended cut-off score of 10 for the EPDS. Two policies and five GP practices offered no cut-off score (Fig 4.1.2).

Figure 4.1.2 Policy and practice cut-off scores for high-risk postnatal depression

The training package in ten policies incorporated the information that normal emotional change following childbirth may be misinterpreted as depression. The implementation of this guidance was not assessed in the practice questionnaire.
Complementary therapies

These were offered as treatment options in clinical practice. GP practices were asked about ‘during the postnatal period’ rather than specifically enquiring about breastfeeding mothers.

Three policies specifically discouraged the use of St John’s Wort during pregnancy and in women who are breastfeeding. However 9% of GP practices stated that they offered this as a treatment option during pregnancy and 13% during breastfeeding. Twenty-seventy per cent of GP practices offered complementary therapies in the postnatal period as a treatment option.

Eight NHS Boards advocated postnatal listening visits by health visitors to women believed to be at high-risk of developing postnatal depression and these were available in 90% of GP practices.

Mother and baby admissions

Six policies recommended that a multi-professional group be involved in the decision to admit a mother with her baby. This was not assessed in the GP practices. Two policies suggested that social work be routinely involved in the decision concerning the admission of mother and baby to hospital and 13% of practices specified that this would be the case.

Integrated care pathway development

In September 2003, six NHS Boards had ICPs in place and a further five intended to develop an ICP during 2004. ICPs were included in the policy documentation in the NHS Board survey.

A range of health professionals responsible for antenatal and postnatal care of women was involved in developing all the ICPs (Table 4.1.4). User representatives were involved in half of the NHS Board areas with ICPs. All ICPs showed evidence of adaptation for local needs. All ICPs addressed the identification and management of postnatal depression. Three of six also addressed identification and management of puerperal psychosis.

Table 4.1.4: Professionals involved in ICP development

<table>
<thead>
<tr>
<th>Profession</th>
<th>N</th>
<th>Profession</th>
<th>N</th>
<th>Profession</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Visitor</td>
<td>6</td>
<td>Voluntary Organisation</td>
<td>4</td>
<td>Social Services</td>
<td>1</td>
</tr>
<tr>
<td>Midwife</td>
<td>6</td>
<td>Clinical Psychologist</td>
<td>3</td>
<td>Education Representative</td>
<td>1</td>
</tr>
<tr>
<td>Community Psychiatric Nurse Manager</td>
<td>5</td>
<td>Service User</td>
<td>3</td>
<td>Clinical Director</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>4</td>
<td>Pharmacist</td>
<td>2</td>
<td>Clinical Development</td>
<td>1</td>
</tr>
<tr>
<td>General Practitioner</td>
<td>4</td>
<td>General Manager</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
All six ICPs included a flowchart for easy reference. Four stated explicit standards to be met (three had eight standards, one had ten). All necessary paperwork was included within one document in two ICPs. Two ICPs included specific documentation reflecting the pathway and facilitating recording of any variance from this to aid evaluation and audit. One ICP included information on training and supervision of staff to support the pathway.

4.1.4 Relationship Between Policy and Practice

In order to explore whether there was a relationship between Board policy and clinical practice at primary care level, the NHS Board guidance relating to the SIGN evidence-based recommendations and good practice points was compared to GP practice responses. Tables 4.1.5 and 4.1.6 show the GP practice responses to SIGN recommendations and good practice points, respectively, according to whether or not the NHS Board included that item in its policy.

The relationship between GP practice and NHS Board policies was only significant for two of the SIGN recommendations and one of the good practice points.

In relation to SIGN recommendations, GP practices were more likely to implement antenatal screening for a history of puerperal psychosis if they were within an NHS Board that recommend this as routine practice. GP practices within Boards that had in-patient facilities for mother and baby admissions were more likely to identify these services as a treatment option than in the areas where the NHS Boards indicated the facilities were unavailable. NHS Board guidance did not relate significantly to the likelihood of GP practices following the other SIGN evidence-based recommendations.

The only significant relationship between NHS Board policy and clinical practice relating to the SIGN good practice points was with the administration times of the EPDS. When the NHS Board policy was in line with the SIGN recommended times the GP practices within the area were more likely to undertake the assessment within the recommended timeframe (p=0.04 for 6-8 weeks and p=0.001 for 12-16 weeks) (Table 4.1.6).
Table 4.1.5: GP practice responses by NHS Board Policy (n=14): Ordered by SIGN Grading

<table>
<thead>
<tr>
<th>GP Practice response</th>
<th>Board Response ‘Yes’</th>
<th>Board Response ‘No’</th>
<th>Sig</th>
<th>P =</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>n (% of N)</td>
<td>N</td>
<td>n (% of N)</td>
</tr>
<tr>
<td>A Antenatal assessment - history of depression</td>
<td>25</td>
<td>23 (92%)</td>
<td>128</td>
<td>111 (87%)</td>
</tr>
<tr>
<td>B Psychological interventions encouraged for PND: CBT IPT</td>
<td>68</td>
<td>31 (46%)</td>
<td>78</td>
<td>36 (46%)</td>
</tr>
<tr>
<td>C Guidance available on medication - breastfeeding</td>
<td>81</td>
<td>73 (90%)</td>
<td>70</td>
<td>63 (90%)</td>
</tr>
<tr>
<td>C EPDS used as screening tool for PND</td>
<td>155</td>
<td>146 (94%)</td>
<td>18</td>
<td>18 (100%)</td>
</tr>
<tr>
<td>C Clinical evaluation with EPDS recommended</td>
<td>138</td>
<td>131 (95%)</td>
<td>30</td>
<td>28 (93%)</td>
</tr>
<tr>
<td>C Family members routinely offered support for PND</td>
<td>49</td>
<td>28 (57%)</td>
<td>104</td>
<td>72 (69%)</td>
</tr>
<tr>
<td>C Interventions with more than one family at a time</td>
<td>79</td>
<td>40 (51%)</td>
<td>68</td>
<td>35 (51%)</td>
</tr>
<tr>
<td>D In-patient facilities for mother and baby admissions</td>
<td>100</td>
<td>48 (48%)</td>
<td>60</td>
<td>15 (25%)</td>
</tr>
<tr>
<td>D Antenatal assessment - history of PP</td>
<td>40</td>
<td>37 (93%)</td>
<td>112</td>
<td>85 (76%)</td>
</tr>
<tr>
<td>D Antenatal assessment - history of psychopathology</td>
<td>37</td>
<td>26 (70%)</td>
<td>112</td>
<td>69 (62%)</td>
</tr>
<tr>
<td>D Antenatal assessment - relative with affective psychosis</td>
<td>83</td>
<td>24 (29%)</td>
<td>68</td>
<td>18 (26%)</td>
</tr>
</tbody>
</table>

♦ These items had insufficient power for Chi² analysis

DF = 1
<table>
<thead>
<tr>
<th>Practice</th>
<th>Board Response ‘Yes’</th>
<th>Board Response ‘No’</th>
<th>Sig</th>
<th>P =</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal psychological support for high-risk of PND</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>81</td>
<td>80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n (% of N)</td>
<td>63 (78%)</td>
<td>61 (76%)</td>
<td>-</td>
<td>0.818</td>
</tr>
<tr>
<td>1st assessment EPDS administered 6-8 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>144</td>
<td>24</td>
<td>***</td>
<td>0.036</td>
</tr>
<tr>
<td>n (% of N)</td>
<td>103 (72%)</td>
<td>12 (50%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2nd assessment EPDS administered 12-16 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>57</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n (% of N)</td>
<td>40 (70%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health professionals trained in EPDS administration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>144</td>
<td>25</td>
<td>♦</td>
<td>0.001</td>
</tr>
<tr>
<td>n (% of N)</td>
<td>130 (90%)</td>
<td>24 (96%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St John’s Wort discouraged - pregnant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>36</td>
<td>102</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n (% of N)</td>
<td>1 (3%)</td>
<td>11 (11%)</td>
<td>-</td>
<td>0.120</td>
</tr>
<tr>
<td>St John’s Wort discouraged - breastfeeding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>38</td>
<td>102</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n (% of N)</td>
<td>1 (3%)</td>
<td>15 (15%)</td>
<td>♦</td>
<td>♦</td>
</tr>
<tr>
<td>Complementary medicine discouraged - breastfeeding</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>33</td>
<td>112</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n (% of N)</td>
<td>5 (15%)</td>
<td>32 (29%)</td>
<td>-</td>
<td>0.120</td>
</tr>
<tr>
<td>Complementary medicine discouraged - pregnant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>26</td>
<td>114</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n (% of N)</td>
<td>0 (0%)</td>
<td>34 (30%)</td>
<td>♦</td>
<td>♦</td>
</tr>
<tr>
<td>Postnatal listening visits for high-risk of PND</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>110</td>
<td>60</td>
<td>-</td>
<td>0.390</td>
</tr>
<tr>
<td>n (% of N)</td>
<td>100 (91%)</td>
<td>52 (87%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient offered selection of psychosocial treatments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>63</td>
<td>87</td>
<td>-</td>
<td>0.138</td>
</tr>
<tr>
<td>n (% of N)</td>
<td>58 (92%)</td>
<td>73 (84%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family involved in mother-baby admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>83</td>
<td>69</td>
<td>-</td>
<td>0.758</td>
</tr>
<tr>
<td>n (% of N)</td>
<td>72 (87%)</td>
<td>61 (88%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social work involved in mother-baby admissions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>144</td>
<td>5</td>
<td>♦</td>
<td>♦</td>
</tr>
<tr>
<td>n (% of N)</td>
<td>20 (14%)</td>
<td>0 (0%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

♦ These items had insufficient power for Chi² analysis

* Offered as treatment option in clinical practice – GP practices were asked about ‘during the postnatal period’ rather than specifically enquiring about breastfeeding mothers

DF = 1
4.2 Other Policy and Practice Issues

4.2.1 Antenatal Use of EPDS

Despite the lack of SIGN guidance to support routine screening in the antenatal period to predict the development of postnatal depression, half the policies recommend routine antenatal use of the EPDS and this is implemented by 52% of practices across Scotland (Table 4.2.1).

<table>
<thead>
<tr>
<th>Policy Use</th>
<th>N</th>
<th>(% of N)</th>
<th>Practice Use</th>
<th>N</th>
<th>(% of N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPDS used routinely antenatally</td>
<td>17</td>
<td>8 (47%)</td>
<td>EPDS used routinely antenatally</td>
<td>185</td>
<td>97 (52%)</td>
</tr>
<tr>
<td>EPDS used routinely antenatally - identify current depression</td>
<td>17</td>
<td>6 (35%)</td>
<td>EPDS used routinely antenatally - identify potential future PND</td>
<td>90</td>
<td>78 (87%)</td>
</tr>
<tr>
<td>EPDS used routinely antenatally - identify potential future PND</td>
<td>17</td>
<td>1 (6%)</td>
<td></td>
<td>91</td>
<td>70 (77%)</td>
</tr>
</tbody>
</table>

The majority of policies recommended antenatal use of the EPDS to identify current depression and the practices that administered it used it to identify current depression (87%) and also to predict future postnatal depression (77%).

4.2.2 Other Issues Relating to EPDS in NHS Board Policies and GP Practice

Further differences between policy and practice in relation to the EPDS are shown in Appendix 11.3, Table 11.3.1. A score greater than the agreed cut-off score triggered various actions in the practice including informing the GP (91% of practices), listening visits (97%) and a health visitor’s review (87% of GP practices). Almost all GP practices (97%) recommended referral to the general practitioner if a woman responded to the self-harm question, and 56% of practices immediately referred her to the Community Mental Health Team. If a woman scored zero on the EPDS this was also likely to result in further action being taken by the health professional in 53% of practices.

The audit also identified other recommendations and trends in relation to administration of the EPDS in the policies of the NHS Boards that were not included in SIGN. Almost universal was the practice of completing the EPDS independently in the presence of a health visitor (95%), with the woman being offered immediate feedback on her score (97%). Discussion of the EPDS during pregnancy without administration was recommended by two policies and implemented in 41% of practices. Almost a third of GP practices discussed the EPDS with the women on a separate occasion prior to administering it. The EPDS was also used outwith the recommended times if a health professional was concerned about the patient (95%) and was repeated, generally a fortnight later, if the woman scored over the locally adopted cut-off score (95%).
In order to see whether there was a relationship between Board policy and actual clinical practice at GP practice level in relation to these items, the NHS Board guidance relating to the EPDS was compared to GP practice responses. In Appendix 11.3, Table 11.3.2, clinical practices in line with Board policy are compared to those where Board policy and clinical practice do not concur.

4.2.3 Auditing of Policy

A majority of the policies (9/14) recommended sample auditing (none continual) of case notes whereas a minority of the GP practices reported that they undertook sample or continual audits (24%) and 5% indicated they did both. Fifty-one per cent of GP practices indicated that they had a recording system developed to facilitate audit, but despite this half of the GP practices that had this system in place were not undertaking audits.

The items that were recorded for audit by the majority (>50%) of practices that undertook audits were EPDS scores, the interventions offered to and undertaken by women when identified with postnatal depression, and referrals to other agencies (Appendix 11.3, Table 11.3.3). Half or fewer of the GP practices recorded identification of antenatal risk factors, the effectiveness of interventions completed, antenatal contact with the health visitor, time delays between referral and appointments with external agencies and variances from standards of care.

No relationships were found between NHS Board policy and practice relating to the audit (Appendix 11.3, Table 11.3.4).

4.2.4 Training

Board policies indicated that training in postnatal mood disorders was on offer or was under consideration in all but 12% of NHS Board areas. In the areas that offered training as part of Board policy only 26% recommended that supervision should be available following training. At practice level, of the 187 GP practices that responded to this question only 26% of GP practices were actually offering clinical supervision to staff in relation to the detection and management of postnatal depression.

4.2.5 Routine Antenatal Care

Eleven policies provided an antenatal ‘risk-factor’ checklist for GP practices and 53% of GP practices implemented a checklist. By considering the policies, 77 items were identified as potential ‘risk-factors’ for postnatal depression. The majority of the factors identified had no evidence-base to support their implementation. All these factors were incorporated into the Board and GP practice questionnaires. Table 4.2.2 presents the ten factors most frequently recorded by GP practices. Eleven policies provided an

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2 The responses from the Lothian NHS Trusts have been extracted from the data when comparisons are drawn between NHS Boards and the practices within them.
antenatal ‘risk-factor’ checklist containing some of the 77 factors for GP practices and 53% of GP practices implemented a checklist.

Table 4.2.2: Most frequently recorded ‘antenatal risk-factors’ for postnatal depression.

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous miscarriages</td>
<td>91%</td>
</tr>
<tr>
<td>Previous neonatal death</td>
<td>90%</td>
</tr>
<tr>
<td>Previous postnatal depression</td>
<td>90%</td>
</tr>
<tr>
<td>Previous perinatal mortality</td>
<td>89%</td>
</tr>
<tr>
<td>Number of other children</td>
<td>89%</td>
</tr>
<tr>
<td>History of depression</td>
<td>88%</td>
</tr>
<tr>
<td>Previous terminations</td>
<td>87%</td>
</tr>
<tr>
<td>Current mental health difficulties</td>
<td>87%</td>
</tr>
<tr>
<td>Alcohol misuse/dependency</td>
<td>86%</td>
</tr>
<tr>
<td>History of mental health difficulties</td>
<td>86%</td>
</tr>
</tbody>
</table>

Fifteen polices recommended that women be offered information about postnatal depression during the antenatal period and 53% of GP practices provided information over and above that provided in ‘Ready Steady Baby’ (Health Scotland, 2004). Thirty-six per cent of GP practices indicated that this information included guidance on how to access local voluntary support groups. The information offered to pregnant women by two policies stated that a child would not routinely be taken into care because the mother has postnatal depression.

One NHS Board had developed an official case register for psychotropic medication during pregnancy but only two of the GP practices within that Board indicated that they contributed to the register. GP practices offered a range of interventions to treat depression in the antenatal period, including cognitive behavioural therapy (46%), interpersonal therapy (41%), psychotropic medication (68%), complementary therapies (23%), and St John’s Wort (9%).

4.3 Qualitative Aspects (Phase 3)

Recruitment figures for Phase 3 of the project are shown in Table 4.3.1. Due to recruitment problems, only a small number of individual interviews (n=8) were carried out and only a small number of participants (n=18) took part in the focus groups. As a result, it is recognised that no conclusions can be drawn. However, the findings from the focus groups have been included as they offer a starting point for further discussion.

Table 4.3.1: Recruitment for Phase 3

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Target Group</th>
<th>Location</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus Group</td>
<td>Maternity Users</td>
<td>Fife</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Glasgow</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Highland</td>
<td>-</td>
</tr>
<tr>
<td>Focus Group</td>
<td>Health Professionals</td>
<td>Fife</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Glasgow</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Highland</td>
<td>5</td>
</tr>
<tr>
<td>Interviews</td>
<td>Ethnic women</td>
<td>Glasgow</td>
<td>5</td>
</tr>
<tr>
<td>Interviews</td>
<td>Voluntary sector</td>
<td>Lothian</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Highland</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fife</td>
<td>1</td>
</tr>
</tbody>
</table>
4.3.1 The Maternity Users’ Experience

A small sample of new mothers took part in the study, some of whom had experienced postnatal depression. It was common that mothers felt that they had not been asked specifically about their emotions after childbirth and that they had had to raise the topic themselves. “Nobody has talked about ...the inside feelings and look at how you feel and, no, no never” (EM2). Many women avoided discussions about their feelings and low mood and were only willing to talk about it in retrospect. One said “I knew myself that there was something not right but I think it was partly denial, that I didn’t want to accept that I wasn’t well and that I couldn’t cope so I didn’t want to tell anybody so I took steps to hide things…” (FG34). Reasons for hiding their feelings included concern about the relationship (would the partner leave them?), concern about possible consequences for the baby and difficulty in acknowledging even to themselves that they were not coping with the new baby.

The EPDS was seen as a possible route into that discussion. The majority of women in this sample reported that they found it easy to complete and felt that it had been adequately explained to them. Problems were reported by the small group of ethnic minority women involved with the study (who were from different ethnic backgrounds). What emerged from their interviews was not simply that they may not have thought they would experience postnatal depression but an absence of any culturally contextualised understanding or awareness of the phenomenon.

The theme of coping (or otherwise) ran through all the users’ discussions, with women reporting considerable pressure to cope or at least be seen to be doing so. This additional pressure constrained their behaviour in a number of ways, including pressurising them to complete the EPDS in a way which would appear socially acceptable. Thus some women reported that they knew what the expected answers were and were able to provide them; this allowed them to continue to hide their feelings and did not offer the opening to dialogue with the health visitor. Some questions, especially question 10 (on suicidal thoughts) were seen as especially threatening; “That’s what I thought as well, it was like ‘have you felt suicidal or something’ like that, and it’s ‘okay, I’m going to be really careful how I answer this” (FG12). One group of mothers in particular, who had all experienced severe postnatal depression, were vocal about their fears about completing the EPDS honestly.

Relationships between health professionals and mothers were seen to be of paramount importance – but experiences were very mixed, with some saying that their health visitor was ‘approachable’ and the GP ‘fantastic’ while others reported that they had not established a good relationship with one and/or the other professional (“my son was eight months old and ..I don’t know who my health visitor is” (FG31). Thus although the EPDS was one route into dialogue with the health visitor, from the mothers’ perspective it was the warmth and intimacy of the relationship that mattered. Some were fortunate in that their GP and health visitor appeared to have good communication which they felt was reassuring.
For the most part, mothers who had experienced postnatal depression felt that once their condition was acknowledged, they were well cared for. Those who had been referred to counselling were particularly enthusiastic about this support: “I took them (medication) and felt better for it, I had counselling as well on the NHS for as long or as often as I needed that, and both of these things really helped”.

4.3.2 Health Visitors’, Community Midwives’ and Voluntary Sector Staff’s Experiences

These groups were asked to describe how and in what ways they addressed mothers’ emotional needs. Almost all reported that they did raise depression with mothers and that this was initially raised during the antenatal contact “We introduce it at the antenatal visit at home and we talk about the service and the sorts of things we offer. So I sort of introduce it at the antenatal visit and take it from there” (FG41). For the most part the aim of the antenatal stage appears to be to alert mothers to the possibility that they may experience mood disturbance but also to create a relationship which would make it easier for women to talk about their feelings. Later they would move to more direct questioning, with health professionals using a variety of approaches to start the dialogue, from “How are you doing” (FG48), “How have you found the first six weeks” (FG41) to more direct questions such as “Is it harder than you expected it to be or is it better?”. Sometimes women were given written advice as well.

While health professionals did voice a concern about identifying postnatal depression in women they were also sometimes reluctant to label a woman’s difficulties as such. At one focus group, the following exchange occurred between a group of health professionals as they discussed what constituted postnatal depression: “What is the difference, depression in the postnatal period is postnatal depression, isn’t it?” “Well, you could go round the houses with that argument because you know it’s circumstances, it’s lifestyle changes, relationship stuff, it’s stuff that has been there maybe long term”…. “It’s also just a stressful, difficult time, isn’t it?” They also knew that women might thwart their attempts to detect depression and it was then that they thought that the EPDS could be a useful device to help mothers acknowledge that they had a problem. The EPDS was, however, seen as only one method of approaching the issue with mothers and rarely the first. There was an awareness that mothers may feel uncomfortable with the assessment and its universality was emphasised as a way of attempting to overcome mothers’ diffidence. “ …If you say ‘this is a routine assessment tool that they use’ it helps us bring up postnatal depression as a subject” (FG54).

FG 55. “I think that’s important, that they know it’s everyone and…”
FG 54. “Yeah, and that it is policy to offer it and that I will be doing it”.
FG 45. “And I also say to the girls, you know, ‘this is not my assessment, this is for the time to think about how you are feeling, lets think about you’…”

Most of the respondents suggested that they emphasised that everyone was assessed and there were variations in how and when it was administered,
with health visitors reporting that they would do it at booking and then antenatally ‘at 28 weeks’ and postnatally ‘at 6 weeks’. When asked about situations when they might not administer the EPDS they gave examples of women who had already been in contact with primary care or psychiatric services.

They reported feeling at ease with asking questions about mood and using the EPDS, using words like ‘comfortable’ and ‘we’re used to it’. They reported that they used the scale to raise concerns with the mother and specific responses to focus discussion. Thus for health professionals the EPDS was seen as a way of opening up discussion of any problems. Health visitors also emphasised that it was not a substitute for clinical judgement. In particular there was an awareness that mothers may not complete the scale honestly, and may wish to mask their emotions, a point raised above by the mothers’ themselves. “That’s a hard one, isn’t it because if they’re not wanting to open up the discussion, y’know, - that’s their opportunity to open that discussion. If they, for whatever reason, don’t want to open that discussion, you can try a few ...other questions, and - you know, I don’t think I would just leave it there, end of story” (FG54).

The health visitors did acknowledge the stigma around reporting mental health problems but did not think that the mothers need be fearful of harsh interventions, a fear which the mothers themselves reported strong views about. One of the voluntary sector staff confirmed “…there’s still the deep fear that someone is going to take the baby away and we hear that all the time [from the mothers]” (VSM).

There were concerns about the EPDS, less as an instrument in itself but rather as a stand-alone tool; none of the professionals thought that it was a substitute for clinical judgement and that nothing substituted for getting to know the clients well antenatally. Those working in voluntary sector settings also had doubts about the EPDS, their views reflecting what mothers had told them (for example, about being covert about one’s emotions).

Thus it was clear that the health professionals used the EPDS routinely but were aware of its limitations as a diagnostic tool. On the other hand, both ante- and postnatally there was an awareness of the existence of the SIGN guidelines and this determined their response to a mother they believed to be suffering from depression. The respondents reported using the various pathways in their practices, for example referring mothers to clinical psychologists, CPN involvement, referral to the GP and thinking about family support. There was confirmation that women were seen quickly by the services and not subject to long waiting lists: “The psychology service fast tracks the girls with postnatal depression so they don’t have to wait on the waiting list, so they are seen very quickly, they can be seen within 2 weeks”(GF48). A large percentage of referrals to the voluntary sector agencies were made via health visitors and the picture that emerged was one of co-operation between voluntary and statutory services.
The respondents were aware of gaps in the services offered to women, and also had an understanding that women often needed social support rather than strictly medical care, something the health visitors were not able to offer. One said “...some of these girls are really isolated and they just really need a gran figure and I don’t think we can meet that need” (FG45). The voluntary sector provides a crucial service but is patchy and limited and locality specific. One voluntary sector staff member felt that “there are other places that are trying to set up groups and outreach services but I think the size of this service and the variety of things that we sort of offer is unique, I think, it’s very unusual” (VSm1).

5. DISCUSSION

5.1 Policy and Practice

One of the clearest findings from the study was the lack of congruence between NHS board policies and the GP practices, with the evidence showing that the practices were further on in implementing SIGN than were the Boards. Thus 47% of the Boards had implemented the majority of the SIGN recommendations compared with 68% of GP practices. While some Boards reported that they were in the process of drafting their policy it may be easier for GP practices to respond more quickly and to react to interest and activity among their staff, than for policy to change at Board level.

Additionally, while most NHS Boards were actively planning services for postnatal depression some of the policies were not congruent with SIGN Guidelines. Thus, for example, a minority provided antenatal support for women at risk of developing postnatal depression, some did not provide clear guidance on appropriate cut-off points for the EPDS, and some recommended antenatal use of the EPDS. Half had a named individual responsible for implementation of SIGN 60 Guidelines.

It was difficult to distinguish patterns of agreement across the GP practices’ activities although there were significant correlations between Board policy and GP practice with regard to provision of in-patient facilities for mother and baby admission and for antenatal assessment of puerperal psychosis. In these instances, GP practices were significantly more likely to implement the SIGN Guideline recommendations if they were recommended by the NHS Board. Not surprisingly, GP practices in the NHS Boards which had in-patient facilities for admission of mothers and babies were more likely to offer in-patient admission as a treatment option. However, the absence of specialist facilities in all NHS Board areas at the time of the audit is a matter of concern; the SIGN recommendation was that these admissions should only be to specialist mother and baby units and the Boards had already had some time to plan for, and establish these facilities.

GP practices were significantly more likely to implement the SIGN Guidelines’ good practice points relating to assessing with the EPDS at 6-8 and 12-16
weeks postnatally if they were recommended by the Board. This suggests that in relation to some activities staff in general practices were more likely to attend to SIGN Guidelines than their own Board policy. This could be because of a greater awareness of the Guidelines at practice level (e.g. by health visitors). Clinical practice under the control of health professionals may be more easily influenced by evidence-based guidelines than NHS Board policy. However some initiatives such as ICPs which cross professional boundaries and require substantial resources and professional input are more likely to be steered by NHS Board policies since they are more difficult to establish at a practice level.

If the Board policy followed SIGN Guidelines, these were followed by GP practices, but where they did not, the GP practices tended to follow SIGN Guidelines anyway. Although the practices were more likely to follow SIGN, they were also more likely to go beyond the guidelines and introduce a range of clinical practices which were not evidence based. This suggests a need for further research to provide an evidence base for clinical practice.

5.2 Use of the EPDS

The second clear finding related to the considerable range of cut-off points for the EPDS which were not evidence based and proposed by SIGN. Although SIGN made a good practice point that 10 should be the cut off point for whole population screening this was not endorsed by most polices or GP practices. Twelve was recommended or used as the cut-off score by most policies and GP practices.

In the use of the EPDS it appears that NHS Board policy is influential in clinical practice. Half the policies recommended antenatal screening and over half the GP practices implemented it despite the lack of any evidence base to support this use of the EPDS or any recommendation from SIGN. The use of the EPDS was strongly recommended by the CRAG report (CRAG, 1996) and this may have been influential in clinical practice. More research into why it is so widely used for antenatal screening is urgently needed.

5.3. Integrated Care Pathways

Despite the SIGN guideline recommending the development of ICPs, 14 months after the publication of the Guideline the majority of NHS Boards had not developed one. By September 2003, only six of the 15 NHS Boards had an ICP in place. All incorporated SIGN recommendations and showed evidence of adaptation for local needs. Only half of the GP practices within these areas were using the ICP. The opportunity for further analysis of their development and implementation was limited.

Across Scotland there is considerable interest in developing ICPs. In December 2004 a Scottish Perinatal Mental Health Network was established to develop a perinatal mental health ICP for NHS Tayside. The group includes

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3The network is led by Mr Michael Sykes. See website at http://www.show.scot.nhs.uk/pmh
health professionals with an interest in perinatal mental health representing all NHS Boards in Scotland. The group aims to develop a core Integrated Care Pathway incorporating minimum standards for postnatal depression in Scotland and local adaptation will be recommended. The results of the NAPD study have contributed to this, fulfilling aim 1.

5.4 Project Difficulties

Two main problems were encountered with the audit, the first more easily overcome than the second. Initially there was difficulty engaging the practices with the project and after various approaches, the most successful one was to involve the health visitors in completion of the questionnaires. The questionnaire required completion by more than one profession and in retrospect it might have been easier to have sent separate questionnaires to each separate professional group.

There were considerable problems with obtaining permission to carry out qualitative interviews and with recruitment. It was very difficult to recruit women into focus groups. There were several possible explanations, including organisational difficulties beyond our control, the sensitivity of the topic, and a lack of interest of women in taking part. The problems experienced in data collection in this part of the study make it difficult to draw conclusions from the focus groups and interviews and the findings should be treated with considerable caution. In particular, the final sample lacked women who had undergone the EPDS but were not in a high risk group. Thus the experiences of women in this study veer to the more extreme end.

6. CONCLUSIONS

1. Minimum standards represented by SIGN 60 evidence-based recommendations were mostly followed in both policy and practice.

2. If NHS Board policy followed SIGN 60 guidelines, the guidelines were more likely to be implemented at general practice level. Overall, practices were more likely to follow SIGN guidelines than were Boards, but they also demonstrated procedures which went beyond those recommended by SIGN.

3. About half of Boards recommended, and general practices used, the EPDS antenatally although this is not recommended by SIGN and is not supported by an evidence base and is therefore a cause for concern.

4. Areas of practice where SIGN guidelines were not adhered to included availability of psychosocial interventions, and some antenatal use and cut-off of the EPDS.
7. ACTIONS REQUIRED AND RECOMMENDATIONS FOR THE FUTURE

1. SIGN should consider the influence of their guidelines on policy as well as on clinical practice.

2. In many instances GP practices were ahead of NHS Board policies in following recommendations and so could be targeted by SIGN to effect more rapid change.

3. Future work should have two aims. Firstly, to update the findings by repeating the current study and secondly, to include an examination of the experiences and outcomes of care received, rather than solely focusing on the process of care.

8. DISSEMINATION

NAPD was launched in October 2003 to try and raise the profile of the project in an attempt to optimise the support offered by practices during Phase 2. The Scottish Executive’s Healthy Living Campaign funded the Launch.

Value was identified in all of the presentations with people indicating that they had gained an insight into the role of NHS QIS, a clearer knowledge of the SIGN Guidelines and a useful overview of the NAPD Project.

- All delegates replied that the relevance of the course to general practice was ‘very relevant’ or ‘relevant’.
- A number of individuals indicated that they were currently involved in developing an ICP. Other delegates said that they had been inspired by the course to consider the need for development of resources within their NHS Board.
- Some felt the content confirmed that the policy they were using was evidence-based and that it was useful to be offered the opportunity to discuss practice issues they were having difficulties resolving.
- Many of the delegates emphasised the benefit of having an opportunity to discuss case scenarios and practice with a range of health care professionals from various areas.
- A number also said that it would have been helpful for the course to be longer in order to have more opportunity for discussion with other health professionals and NAPD team members.

NAPD hosted two events in Glasgow and Perth during June 2005 to disseminate the findings of the study. The events were extremely popular and were attended by over 180 delegates.

- Delegates considered the events to be relevant to their practice and the events met with their expectations.
• They indicated that they had a better understanding of PND, the policies associated with it, greater insight into national agendas and local organisation, what women want from services and what services are available.
• Delegates found it a useful opportunity for dialogue with professionals from other areas and other disciplines.
• Many of the delegates indicated that they intended to improve their own practice by applying new knowledge and exploring local opportunities to link with other professionals.
1st October 2003 18.30 – 21.00
The Royal College of Physicians and Surgeons of Glasgow, Glasgow
Launch of the National Audit of Postnatal Depression
Delegates Attended: 49 Delegates registered: 80
6.00 BUFFET MEAL Registration
Chair Prof. Margaret Reid
6.30 Prof. Beth Alder Welcome
6.35 Mr Sean Doherty NHS QIS
6.40 Dr Roch Cantwell SIGN 60 Guidelines: development and evidence-based practice.
6.50 Mrs Anna Daley Outlining the SPICE Postnatal Depression Criteria
7.00 Prof. Beth Alder Introducing the National Audit of Postnatal Depression (NAPD)
7.20 Prof. Margaret Reid Questions
Chair Dr Barbara Ballinger
7.30 Dr Barbara Ballinger Introduction of small group task.
7.35 Small Group Task 3 scenarios: consider application of ICP and potential problems
8.30 Dr Barbara Ballinger Discussion – feedback on scenarios
Supported by the Scottish Executive National Programme to improve Mental
Health and Well Being and the Mental Health Division.
2nd June 2005 10.00-3.30
Quality Station Hotel, Perth
Postnatal Depression in Scotland: Where are we now and where next?
Delegates Attended: 85 Delegates registered: 91
10.00 TEA & COFFEE Registration
Chair Prof. Margaret Reid
10.30 Dr Margaret McGuire Maximising the health and well-being of women following childbirth
11.00 Prof. Beth Alder Where are we now?
11.30 Dr Laura Sharp NAPD: What did we find?
11.45 Ms Liz Kearney How is the EPDS being used across Scotland?
12.00 Mrs Noreen Wright A user’s perspective
12.10 Dr Barbara Ballinger Questions
12.30 LUNCH
Chair Prof. Beth Alder
13.30 Dr Roch Cantwell Specialist services for perinatal mental illness
13.45 Prof. Margaret Reid Women’s Experiences of Services
14.00 Dr John Loudon The NHS and Integrated Care Pathways
14.30 Dr Barbara Ballinger Questions: TEA & COFFEE
9th June 2005 10.00-3.30
Wolfson Medical School, Glasgow University, Glasgow
Postnatal Depression in Scotland: Where are we now and where next?
Delegates Attended: 101 Delegates registered: 96
10.00 TEA & COFFEE Registration
Chair Prof. Margaret Reid
10.30 Ms Maureen Houston The Impact of PND on Infants
11.00 Prof. Beth Alder Where are we now?
11.30 Dr Laura Sharp NAPD: What did we find?
11.45 Ms Liz Kearney How is the EPDS being used across Scotland?
12.00 Prof. Margaret Reid Questions
12.30 LUNCH
Chair Prof. Beth Alder
13.30 Ms Karen Robertson Specialist services for perinatal mental illness
13.45 Prof. Margaret Reid Women’s Experiences of Services
14.00 Mrs Shona Cowan Doing well by people with Depression Programme
14.30 Prof. Beth Alder Questions: TEA & COFFEE
8.1 Presentations, Conferences & Published Abstracts


Sharp L. This study needs you: Issues around recruitment and response rate. Napier University School of Community Health Research Seminar, 3rd November 2004, Edinburgh.


8.2 Distribution of the Final Report

Following approval from NHS QIS the full report will be distributed to the lead individual in each NHS Board for perinatal mental health, NHS Board medical directors, RCGP, Health Visitors Association, the relevant voluntary agencies, SIGN, ISD, and chairs of relevant SEHD committees. During the period of the study a database of supportive practices and individuals that wish to be kept updated on the progress of the study has been developed. Copies of the executive summary will be distributed to individuals in this database.
9. REFERENCES


CRAG. CRAG Report on detection and early intervention in postnatal depression. CRAG, Scottish Executive Health Department, Edinburgh, 1996.


10. ACKNOWLEDGEMENTS

We are grateful for the encouragement and advice offered by the NAPD steering group:

- **Ms Sally Amor**, Public Health Specialist, Highland NHS Board
- **Ms Beatrice Cant**, Senior Programme Manager, NHS QIS
- **Ms Fiona Dagge-Bell**, Senior Midwife, NHS QIS
- **Dr Moira Kennedy**, General Practitioner, Tayside NHS Board
- **Mr Hugh Masters**, Senior Lecturer in Mental Health, Napier University
- **Dr Alastair Philp**, Project Manager, NHS Scotland ISD
- **Dr Ian Pullen**, Principal Medical Officer/Psychiatric Adviser, Scottish Executive
- **Mrs Tracy Reilly**, User Representative

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- **Nan Newall**, Mental Health Improvement Officer, Ayrshire & Arran
- **Robert Crawford**, Community Psychiatric Nurse, Hawick, Borders
- **Mary Armour**, PND Project Manager, Dumfries & Galloway (Current post: Sure Start Health Co-ordinator, Luton)
- **Jim Slaven**, Clinical Development Nurse, Fife NHS Board
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- **Janice Longford**, Clinical Services Manager, Lanarkshire
- **Philip Harrison**, Service Manager, West Lothian, Lothian
- **Maria Wilson**, Acting Principal Midwife, Lothian Acute Trust, Lothian
- **Ann Marie Burgess**, Lead Health Visitor, Lothian Primary Care Trust, Lothian
- **Gill Cooke**, Health Visitor, Orkney
- **Helen Ward**, General Practitioner, Shetland
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- **Michael Sykes**, Project Manager, TARPC, Tayside
- **Ellena Macdonald**, Senior Midwife, Western Isles

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11. APPENDICES

Appendix 11.1 - NHS Board Questionnaire (see separate document)
Appendix 11.2 - GP Practice Questionnaire (see separate document)
Appendix 11.3 - Results Data Tables
Appendix 11.4 – SIGN Guidelines
### Table 11.3.1: Routine Use of the EPDS

<table>
<thead>
<tr>
<th>Policy</th>
<th>Yes</th>
<th>Practice</th>
<th>Yes</th>
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<tr>
<td></td>
<td>N</td>
<td>n (% of N)</td>
<td>N</td>
</tr>
<tr>
<td>EPDS routinely discussed but not completed antenatally</td>
<td>17</td>
<td>2 (12%)</td>
<td>93</td>
</tr>
<tr>
<td>EPDS routinely discussed but not completed postnataally</td>
<td>16</td>
<td>7 (44%)</td>
<td>90</td>
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<tr>
<td>EPDS completed independently in presence of health visitor</td>
<td>16</td>
<td>15 (94%)</td>
<td>192</td>
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<tr>
<td>Is the woman offered immediate feedback on EPDS score</td>
<td>16</td>
<td>14 (88%)</td>
<td>195</td>
</tr>
<tr>
<td>If HV concerned EPDS used outside recommended times</td>
<td>17</td>
<td>10 (59%)</td>
<td>194</td>
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<tr>
<td>Is the EPDS repeated if score over cut-off</td>
<td>16</td>
<td>12 (75%)</td>
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<tr>
<td>Ethnic/cultural issues considered when administering EPDS</td>
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<td>5 (31%)</td>
<td>186</td>
</tr>
<tr>
<td>Is the EPDS available in other languages within the practice</td>
<td>16</td>
<td>4 (25%)</td>
<td>195</td>
</tr>
<tr>
<td>EPDS offered to any woman new to area with child less than 1 year</td>
<td>16</td>
<td>4 (25%)</td>
<td>194</td>
</tr>
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<td>Is the EPDS ever administered by post</td>
<td>16</td>
<td>2 (13%)</td>
<td>195</td>
</tr>
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<td>Is the EPDS ever administered by telephone</td>
<td>16</td>
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<tr>
<td>Is the woman offered immediate feedback on EPDS score</td>
<td>16</td>
<td>12 (75%)</td>
<td>194</td>
</tr>
<tr>
<td>If HV concerned EPDS used outside recommended times</td>
<td>91</td>
<td>86 (95%)</td>
<td>192</td>
</tr>
<tr>
<td>Is the GP automatically informed if score over cut-off</td>
<td>160</td>
<td>145 (91%)</td>
<td>11</td>
</tr>
<tr>
<td>Are listening visits offered if score over cut-off</td>
<td>124</td>
<td>121 (98%)</td>
<td>45</td>
</tr>
<tr>
<td>Is a health visitors review organised if score greater than cut-off off</td>
<td>160</td>
<td>144 (96%)</td>
<td>54</td>
</tr>
<tr>
<td>Referral to CMHT if positive response to self-harm question</td>
<td>160</td>
<td>143 (95%)</td>
<td>55</td>
</tr>
<tr>
<td>Referral to CMHT if positive response to self-harm question</td>
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<td>142 (94%)</td>
<td>56</td>
</tr>
<tr>
<td>Referral to GP if positive response to self-harm question</td>
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<td>57</td>
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<td>58</td>
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<tr>
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<td>160</td>
<td>139 (91%)</td>
<td>59</td>
</tr>
<tr>
<td>Referral to CMHT if positive response to self-harm question</td>
<td>160</td>
<td>138 (90%)</td>
<td>60</td>
</tr>
<tr>
<td>Does a zero score on EPDS result in further action</td>
<td>160</td>
<td>137 (90%)</td>
<td>61</td>
</tr>
<tr>
<td>Is the EPDS used repeatedly to monitor progress of depression</td>
<td>160</td>
<td>136 (90%)</td>
<td>62</td>
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</table>

### Table 11.3.2: Practice response by NHS Board Policy: EPDS

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<thead>
<tr>
<th>Board Response</th>
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</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>n (% of N)</td>
<td>N</td>
</tr>
<tr>
<td>EPDS used routinely antenatally</td>
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<td>41 (65%)</td>
</tr>
<tr>
<td>EPDS used routinely antenatally to identify current depression</td>
<td>52</td>
<td>32 (62%)</td>
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<tr>
<td>EPDS used routinely antenatally to identify potential future PND</td>
<td>5</td>
<td>2 (40%)</td>
</tr>
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<td>EPDS routinely discussed but not completed antenatally</td>
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<td>2 (8%)</td>
</tr>
<tr>
<td>EPDS discussed but not completed postnatally</td>
<td>94</td>
<td>15 (16%)</td>
</tr>
<tr>
<td>EPDS completed independently in presence of health visitor</td>
<td>153</td>
<td>146 (95%)</td>
</tr>
<tr>
<td>Is the woman offered immediate feedback on EPDS score</td>
<td>138</td>
<td>136 (99%)</td>
</tr>
<tr>
<td>If HV concerned EPDS used outside recommended times</td>
<td>91</td>
<td>86 (95%)</td>
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<tr>
<td>Is the EPDS repeated if score over cut-off</td>
<td>110</td>
<td>104 (95%)</td>
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<td>Is the GP automatically informed if score over cut-off</td>
<td>160</td>
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<tr>
<td>Referral to CMHT if positive response to self-harm question</td>
<td>160</td>
<td>138 (90%)</td>
</tr>
<tr>
<td>Does a zero score on EPDS result in further action</td>
<td>160</td>
<td>137 (90%)</td>
</tr>
<tr>
<td>Is the EPDS used repeatedly to monitor progress of depression</td>
<td>160</td>
<td>136 (90%)</td>
</tr>
</tbody>
</table>

* These items had insufficient power for Chi² analysis

DF = 1
Table 11.3.3: Auditing

<table>
<thead>
<tr>
<th>Policy</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>n (% of N)</td>
</tr>
<tr>
<td>Audit: Risk factor identification</td>
<td>9</td>
</tr>
<tr>
<td>Audit: EPDS score time 1</td>
<td>9</td>
</tr>
<tr>
<td>Audit: EPDS score time 2</td>
<td>9</td>
</tr>
<tr>
<td>Audit: Any other EPDS scores</td>
<td>9</td>
</tr>
<tr>
<td>Audit: Interventions offered</td>
<td>9</td>
</tr>
<tr>
<td>Audit: Interventions undertaken</td>
<td>9</td>
</tr>
<tr>
<td>Audit: Effectiveness of intervention</td>
<td>9</td>
</tr>
<tr>
<td>Audit: Referrals to other agencies</td>
<td>9</td>
</tr>
<tr>
<td>Audit: Antenatal contact with HV</td>
<td>9</td>
</tr>
<tr>
<td>Audit: Time from referral and appointment</td>
<td>9</td>
</tr>
<tr>
<td>Audit: Variance in standard of care</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 11.3.4: Practice response by NHS Board Policy: Auditing

<table>
<thead>
<tr>
<th>Board Response ‘Yes’</th>
<th>Board Response ‘No’</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>n (% of N)</td>
</tr>
<tr>
<td>Audit undertaken within practice</td>
<td>107</td>
</tr>
<tr>
<td>Audit: Risk factor identification</td>
<td>69</td>
</tr>
<tr>
<td>Audit: EPDS score time 1</td>
<td>78</td>
</tr>
<tr>
<td>Audit: EPDS score time 2</td>
<td>78</td>
</tr>
<tr>
<td>Audit: Any other EPDS scores</td>
<td>69</td>
</tr>
<tr>
<td>Audit: Interventions offered</td>
<td>74</td>
</tr>
<tr>
<td>Audit: Interventions undertaken</td>
<td>69</td>
</tr>
<tr>
<td>Audit: Effectiveness of intervention</td>
<td>11</td>
</tr>
<tr>
<td>Audit: Referrals to other agencies</td>
<td>74</td>
</tr>
<tr>
<td>Audit: Antenatal contact with HV</td>
<td>69</td>
</tr>
<tr>
<td>Audit: Time from referral and appointment</td>
<td>11</td>
</tr>
<tr>
<td>Audit: Variance in standard of care</td>
<td>46</td>
</tr>
</tbody>
</table>

♦♦ These items had insufficient power for Chi² analysis
DF = 1
Appendix 11.4 - SIGN 60 Guidelines

Evidence-Based Recommendations

A: Procedures should be in place to ensure that all women are routinely assessed during the antenatal period for a history of depression. P4

C: The EPDS should be offered to women in the postnatal period as part of a screening programme for PND. P5

C: The EPDS is not a diagnostic tool. Diagnosis of PND requires clinical evaluation. P5

D: All women should be screened during pregnancy for previous puerperal psychosis, history of other psychopathology (especially affective psychosis) and family history of affective psychosis. P5

B: PND should be treated. P7

B: Psychosocial interventions should be considered when deciding on treatment options for a mother diagnosed as suffering from PND. P9

C: The effects of a mother’s PND on other family members and their subsequent needs should be considered and treatment offered to them as appropriate. P9

C: Interventions that work with more than one family member at a time should be considered when assessing the treatment options available. P9

D: The option to admit mother and baby together to a specialist unit should be available. Mother and babies should not be admitted to a general psychiatric ward routinely. P10

B: The risks of stopping tricyclic or SSRI antidepressant medication should be carefully assessed in relation to the mother’s mental state and previous history. There is no indication to stop tricyclic or SSRI antidepressant medication as a matter of routine in early pregnancy. P12

C: There is no clinical indication for women treated with TCAs (other than doxepin) paroxetine, sertraline, or fluoxetine to stop breastfeeding, providing the infant is healthy and its progress monitored. P14
**Good Practice Points**

Women with positive risk factors for puerperal psychosis should receive specialist psychiatric review. P5

The EPDS should be used at approximately six weeks and three months following delivery and should be administered by trained Health Visitor or other health professionals. P5

A cut off on the EPDS of 10 or above is suggested for whole population screening. P5

When assessing women in the postnatal period it is important to remember that normal emotional changes may mask depressive symptoms or be misinterpreted as depression. P5

St John’s Wort and other alternative medicines should not be used during pregnancy and lactation until further evidence as to their safety in these situations is available. P8

The effects of a mother’s postnatal depression on other family members and their subsequent needs should be considered as appropriate. P9

In high-risk women it may be effective to have postnatal visits, interpersonal therapy and/or antenatal preparation. P10

A multi-professional assessment, including social work, and involving family members, should take place to review the decision to admit mother and baby to a specialist unit either before or shortly after admission. P10

The development of an integrated care pathway should involve representatives from all health professions engaged in the provision of ante- and postnatal care and service user representatives. The ICP should relate to local needs and circumstances. P17

The ICP should be presented in a user-friendly and succinct format. P17

The ICP should include specific documentation reflecting the pathway and facilitate recording of any variance from this to aid evaluation and audit. P17

Mechanisms should be in place to ensure the orientation of all staff (current and newly appointed) to the ICP. Adequate training and ongoing supervision should be available for staff with identified knowledge or skill deficits related to the ICP. P17