Co-ordinated care for women with postnatal depression

In many cases, postnatal depression is not identified or treated early enough, often as a result of poor co-ordination between the health professionals involved. This article outlines a project to develop multidisciplinary working to improve the care provision for women with postnatal depression.

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KEY WORDS
Postnatal depression (PND) affects between 10 and 15 per cent of women in the first postnatal year (Cox et al 1993, Kumar 1984, Watson et al 1984). In Dundee, with an annual birth population of approximately 2,000, 200-500 (10-15 per cent) of women experience PND. Health professionals are concerned not only with the effects that PND has on the woman (Cox 1994, Stein et al 1991), but also with the effects it can have on the baby, siblings, partner and wider family group (Anders et al 1992, Ballard et al 1994, Birtchenell 1993, Mitchell 1992, Stein et al 1991). In a recent report, the Clinical Audit Resource Group (CARG) (1996) stressed the importance of early detection and intervention for women with PND. The CARG group recommended closer collaboration between all professionals involved in the care of postnatal women, with particular emphasis on HVs, CPNs and joint training initiatives, which they costed (CARG 1996). CARG also advocated strongly the routine screening of women using the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al 1987).

POSTNATAL AFFECTIVE DISORDERS
There are three categories of affective disorders following childbirth (Table 1). O'Hara (1988) suggested that the disorders should be viewed as a continuum of ascending severity, rather than distinct and separate entities.

EFFECTS OF PND
Mothers who have experienced postnatal depression speak of feeling robbed of what should have been a happy time in their lives (Cox et al 1993). The Bromley PND scale has been designed and tested to look at current and previous episodes, and may facilitate longitudinal studies (Stein and Van den Akker 1992). Stein et al (1991) found an association between PND and negative effects on mother–child interaction. Postnatally depressed mothers were less facilitating and their children showed less affective sharing and sociability with strangers at two and three years of age. Anders et al (1992) discovered a link between postnatally depressed mothers and sleep disturbance in their babies (aged between zero and eight months). Effects on family functioning have been noted (Mercer 1990), as has increased psychiatric morbidity in fathers whose partners had recently experienced or were experiencing PND (Ballard et al 1994). Some researchers have also begun to look at the incidence of sudden infant death syndrome (SIDS) and accidental injury to children whose mothers are postnatally depressed (Mitchell 1992), concluding PND to be a significant risk factor for SIDS.

THE DUNDEE PILOT
With the implementation of the Community Care Act (Scotland) in April 1992, members of Dundee's mental health and health visiting teams became increasingly aware of the patchy nature of service provision for women (and their partners, carers and families) experiencing and dealing with postnatal depression.
Several practitioners within their own units – including the psychiatric outpatient department, community mental health resource team (CMHRT), community psychiatric nurse department and health visitor teams – had some expertise, but there seemed to be little communication or networking between them.

An unpublished audit carried out by a consultant psychiatrist and one of the authors at the CMHRT, in the first year of opening, revealed 21 women were referred with PND. This accounted for just under one third of all female referrals. In addition to this, the average treatment time at the CMHRT was then 3.75 months, whereas the PND group had an average treatment time of 6.5 months, identifying them as a group with separate needs to others presenting to our crisis service.

The catalyst for change came with the formation of Dundee Health Care NHS Trust in April 1993. This placed all the agencies under one umbrella, with joint management structures at a higher level giving greater scope for multidisciplinary working.

TRAINING COURSE
We discussed the gaps in local service provision with our community nurse manager (CNM). We applied to attend the training course developed by Elliot et al (1993) and organised by the Sainsbury Centre for Mental Health in London.

The course, entitled The Management of Post-natal Depression, is designed to:

- Prepare a number of key individuals in each area, who can then train, facilitate and support groups of health visitors
- Facilitate better interagency working practice
- Generate ways of developing and adapting existing resources to improve the service provision for this client group.
- The introduction to the two-day course covered:
  - Research evidence
  - Routine screening of postnatal women using EPDS (developed by Cox et al 1987)
  - Health visitor 'listening visits' for women identified by the EPDS as postnatally depressed.

There was discussion about the impetus for change, and about potential problems we might meet.

IMPLEMENTING CHANGE
Following a feedback session with our CNM, we arranged a series of multidisciplinary working parties which brought us together with key health visitors representing each zone of Dundee, their CNM and our joint line manager. We presented several interim proposals for potential service development, most notably the implementation of the health visitor training course.

STRUCTURE OF TRAINING
Twelve health visitors (four from each zone) were selected by their CNM to attend the training. Ten two-hour sessions were held every two weeks, and when health visitors were unable to attend, sessions were tape recorded. We took turns to facilitate the sessions.

We adapted the Sainsbury Centre sessions to meet local needs,
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emphasising throughout that the process was two-way and also an important learning experience for us. A variety of media and other approaches were used in each session. Some of these, including overhead slides, PND handbooks and a video, were provided in our original educational package. We compiled others ourselves, including information on medication, local mental health service provision and multidisciplinary case presentations. Box 1 shows the interventions that health visitors agreed to implement.

EVALUATION
The health visitors are still collating data for their audit. Our results appear to be comparable with other research, suggesting that between 65 per cent and 70 per cent of mothers show less depressive symptomatology three months after their first health visitor intervention (Elliot et al 1993, Holden 1989).

With help from our project supervisor and local manager, we designed questionnaires to find out how those attending the course perceived changes in a number of key areas. These were completed anonymously, before the course, just after the course and six months post-course. The questionnaire was designed to assess perceptions of the following:

- Knowledge base – aetiological factors and current research
- Clinical practice – use of EPDS, role of counselling
- Management and treatment issues
- Role definitions and boundaries – attitudes towards interagency working and role blurring.

Some of the initial results are shown in Figures 1-4 (Figures differ pre- and post-course because one health visitor was late in joining the course).

INITIATIVES
Since the Dundee pilot study, there have been a number of encouraging initiatives.

PND forum A multidisciplinary interest group meets monthly to discuss current issues and look at ways of improving networking.

Symposium In March 1996, Dundee Health Care NHS Trust and Lillie Industries supported a perinatal depression symposium which attracted major national and international speakers. This was very successful in raising awareness about postnatal depression.

Standard setting group A multidisciplinary group has been established to look at formalising the screening of all postnatal women using the EPDS at predetermined intervals (Elliot et al 1993).

Support group Two PND support groups are running within Dundee, a third is planned. An in-depth audit has been planned to look at the efficacy of these projects and interim results (for example, consumer satisfaction) look promising.

IMPROVEMENTS
We think that these initiatives have brought about a number of improvements:

- The standard of communication between the respective agencies has improved
• There is less delay in identifying and treating postnatally depressed mothers
• There are more opportunities for different agencies to work together and share care
• Although the number of admissions to the local mother and baby inpatient unit has not changed, the average duration of stay has decreased from 12.2 weeks to 6.75 weeks (taking averages over the past ten years and comparison with year September 1994-1995).

FUTURE RECOMMENDATIONS
The future development of the service has been planned in the short and longer term.

Short term

• Repeat health visitor training course
• Introduce EPDS as a screening tool for all postnatal women in the area.
• Long term
• Consult service users and purchasers about perceptions on the quality and standard of care
• Set up multidisciplinary working party to look into setting up an integrated service for PND.

CONCLUSION
All the healthcare professionals involved in the pilot and subsequent developments think that we have begun to make a difference to the standard of care for this client group and their families. We hope, by consulting with service users and purchasers that we can begin to provide a service which is relevant and responsive to women and their families.

PND trainers courses now run in England and Scotland, for information contact:
Philip Bell, Business Development Centre, Queen Margaret College, Edinburgh. Tel: 0131 539 7095.
Diane Jackson, University of Keele, Stoke on Trent. Tel: 01782 716291.

REFERENCES
Community Care Act (Scotland) (1992) London, HMSO.
Cox JL, Murray D, Chapman G (1993) A controlled study on the onset,

### Table 1. Postpartum affective disorders

<table>
<thead>
<tr>
<th></th>
<th>Incidence</th>
<th>Onset</th>
<th>Characterised by</th>
<th>Comments (per 1,000 deliveries)</th>
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<tr>
<td>Postnatal 'blues'</td>
<td>500-800</td>
<td>3-5 days postpartum</td>
<td>Emotional lability</td>
<td>Tearfulness Self-limiting, but be vigilant for underlying depression</td>
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<td></td>
<td>(Cox 1994)</td>
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<tr>
<td>Postnatal depression</td>
<td>100-150</td>
<td>Gradual: 50 per cent by three months postpartum; 75 per cent by six months</td>
<td>Clinical depression (diagnosable by psychiatric interview) in first postnatal year</td>
<td>Possible long term negative effects on child/sibling development Possible long term effects on family functioning Risk of</td>
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Postnatal women have nine times increased risk of episode over non-puerperal women. Requires urgent psychiatric referral. Usually responds well to treatment. Risk of subsequent postnatal episode (1:2)

| Puerperal psychosis | Typically rapid – within 14 days postpartum Dramatic presentation – delusional, confused, depressed | Postnatal depression |

Box 1. Health visitor interventions with mothers

Information
Women given information antenatally about:

- Postnatal blues
- Postnatal depression
- Use of Edinburgh Postnatal Depression Scale
- Local support networks available locally

Screening
Postnatal women screened at three preset intervals, as indicated by research
Women scoring 12 or more to be referred to GP

Support
Health visitor ‘listening visits’ (supportive counselling) offered to women scoring 12 or more on EPDS
Progress assessed
Four further visits offered if necessary (Elliot et al 1993, Holden 1989)

Referral
Referral to other agency to be discussed with all concerned if no progress noted
Fig. 1. Aetiology: Indicate level of understanding re psychological theories implicated in the possible development of postnatal depression

![Bar chart showing perceived level of understanding before and after a course.](image)

Fig. 2. In your professional opinion how valuable/effective a tool do you feel EPDS to be?

![Bar chart showing perceived level of usefulness before and after a course.](image)

Fig. 3. Indicate level of awareness/understanding of management treatment of postnatal depression

![Bar chart showing perceived level of awareness before and after a course.](image)
Fig. 4. Following referral to mental health services how involved do you think you should be with your client?