Views of healthcare staff and mothers about postnatal depression screening

This study compared practitioners’ and mothers’ opinions on the use of a screening tool in health care

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Abstract


Background: More research is needed on views of using the Edinburgh Postnatal Depression Scale to screen recent mothers for this condition.

Aim: To examine healthcare professionals’ and mothers’ views of using this tool.

Method: Findings of two qualitative studies on screening for postnatal depression were compared to provide an overview.

Results: There were differences in views within and between groups, although all practitioners found the tool helpful for introducing the topic. Symptom disclosure was an issue for all, although practitioners were unaware that some mothers feared their child would be taken into care.

Conclusion: Pragmatic reasons (such as lack of time and resources) meant practice was not always optimal but, if recommendations are followed, mothers may be encouraged to disclose symptoms.

Introduction

Postnatal depression (PND) is the most common medical problem new mothers face, affecting around 10–15% (Lee et al, 2004). Left untreated, it can persist for many months with adverse consequences for mothers, children and families (Josefsson et al, 2001).

This article brings together data from two previously published studies (Mason and Poole, 2008; Poole et al, 2006) which explored views of health professionals and recent mothers on screening for PND using the Edinburgh Postnatal Depression Scale (EPDS).

We wanted to highlight issues of concern to both groups and to assess how comfortable they were with the screening process. Comparisons and contrasts of views were sought and highlighted.

Literature review

Primary care providers have the most contact with postpartum mothers and are well placed to assess and identify PND. However, primary healthcare professionals detect fewer than half of cases (Hearn et al, 1998).

The reasons for this are complex but can be viewed under the following categories – mothers, healthcare professionals or systems of care. Mothers may not seek help or may mask symptoms because they are reluctant to be identified as having PND (Poole et al, 2006). Healthcare staff may lack training or experience in assessing the condition (Mason and Poole, 2008; Appleby et al, 2003). Additionally, resource constraints can limit their ability to provide coordinated postnatal care, and fragmented responsibility may lead to cases being missed.

Nevertheless, there has been much research on the use of screening tools to identify mothers with PND (Elliott and Leverton, 2000). The most commonly used is the EPDS (Boyd et al, 2005; Cox et al, 1987), a 10-item self-report scale designed to assess the presence and severity of depressive symptoms in recent mothers. Despite its frequent use, there are issues around sensitivity and specificity (Leverton and Elliott, 2000). For this reason, current guidelines suggest the EPDS should not be used as a ‘pass/fail’ tool but as a framework for assessing mothers’ moods that also incorporates a clinical interview. Many trusts in England have developed care pathways for the identification and treatment of PND based on these guidelines. Similarly, Scottish guidance supports the use of the EPDS in this context (SIGN, 2002).

Although the acceptability of screening tools has been widely researched for some conditions, this is not the case with the EPDS. Results of a small number of studies on mothers’ views of screening using this measure have been mixed (Buist et al, 2006; Gemmill et al, 2006; Poole et al, 2006). While the majority found it acceptable, a significant minority did not. Practitioners’ views appear similar, though data on this is even more limited. We found only one study, which showed 25% were ‘somewhat’ or ‘very’ uncomfortable using it (Buist et al, 2006). Box 1 outlines the study’s aims.

Method

The project was conducted in one PCT. Ethical approval was obtained from the local NHS and the university ethics committees. A qualitative approach was adopted, using interpretative phenomenological analysis (IPA), which aims to gain an understanding of the individual’s perspective regarding their experiences.

Two rounds of semi-structured interviews were undertaken with both groups, with individual interviews and focus groups. The interviews were conducted by an experienced interviewer and audio recorded. The interviews were transcribed and a thematic analysis was conducted by the first author.

Results

There were differences in views within and between groups, although all practitioners found the tool helpful for introducing the topic. Symptom disclosure was an issue for all, although practitioners were unaware that some mothers feared their child would be taken into care.

Conclusion: Pragmatic reasons (such as lack of time and resources) meant practice was not always optimal but, if recommendations are followed, mothers may be encouraged to disclose symptoms.

Implications for practice

● Healthcare professionals should only undertake screening if they have the time to carry it out and both the time and ability to deal with unforeseen consequences.

● Practitioners should prepare mothers, ensure they know the procedure is routine and reassure them about the likely consequences of a positive result, specifically relating to family welfare.

● Screening should be carried out in privacy, preferably at mothers’ homes and not repeated within a short time.

● During screening, mothers should be given the opportunity to ask questions or discuss their answers so it should become more than simply ticking boxes.

● Following screening, practitioners should give feedback and reassurance.