November 2010

Detection and Management of Mothers with Postnatal Depression Symptoms

- A Public Health Nurse Descriptive study

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Rationale

Postnatal depression (PND) effects about 10 – 15% of the maternal population often lasting up to one year or more (SIGN 2002). A Dublin study by Crotty and Sheehan (2004) found a 14.4% prevalence rate of PND in the community. If left untreated it can become a chronic condition (SIGN 2002).

PND can have adverse effects on the family and children's development. A review of evidence suggests brain development is most rapid during infancy and delayed development can be the result of maternal depression or poverty (HSE 2006). Findings from a study by Cooper and Murray (1998) indicate that children of 5 years of age whose mothers had postnatal depression, were more likely to be reported by their teachers as having behaviour problems. In addition, fathers are significantly more likely to suffer from depression if their partners are diagnosed with postnatal depression (SIGN 2002).

Symptoms of postnatal depression.

Postnatal Depression is described as a mild to moderate, non psychotic depressive illness that can occur in the antenatal as well as postnatal period and left untreated can last up to a year or more. It is distinguished from 'baby blues' which is a brief period of misery occurring within the first week post natal, effecting a half of all mothers and resolves without treatment.

The two main symptoms of postnatal depression where inquiry should be made are a persistent low mood and a lack of enjoyment or looking forward to things (Whooley et al 2007). Symptoms also include difficulty sleeping, early waking, fatigue, loss of weight, loss of appetite, feelings of guilt, inadequacy, hopelessness and despair, anger or emptiness. It is distinguished from Puerperal Psychosis which is a serious mood disorder. Puerperal psychosis may include thought disturbances, hallucinations and loss of contact with reality. Hospitalisation is usually necessary (SIGN 2002).

Risk factors

Main risk factors include a previous history of depression, low social support, poor marital relationships and prolonged 'baby blues, 'in the early postnatal days Weaker risk factors include a difficult delivery, a history of abuse, low family income and lower occupational status. (SIGN 2002)

Stigma

The stigma attached to postnatal depression often means that sufferers do not get help and continue to suffer alone (SIGN 2002). Fear of stigma resulted in some mothers lying in their answers on the EPDS Scale (NICE 2007). One study found that mothers admitting to depression feared they could risk the baby being taken away (Shakespeare et al 2006).

Evidence base for screening for postnatal depression

Postnatal depression is often missed by primary care teams despite the fact that simple reliable detection tools have been developed (Cooper and Murray 1998**)**

Early detection of postnatal depression can be effectively achieved by trained primary health care workers by screening mothers using a questionnaire called the Edinburgh Postnatal Depression scale (EPDS) tool (SIGN 2002). The EPDS scale is a 10 item self report screening questionnaire used to improve the detection rates of postnatal depression in the community. An advantage of its routine use is that it gives mothers 'permission to speak' and health professionals 'permission to listen' (Cox and Holden 2003). Caution should be applied when using it on women whose first language is not English or where the acceptability of screening for depression may be an issue in some cultures (Cox and Holden 2003)

Listening visits
A review of evidence suggests early detection and intervention for mothers with PND allows mothers to respond to baby's cries and cues and leads to fewer maternal depressive episodes and increased self esteem. (HSE 2006). Offering supportive listening visits by a health professional to mothers with high scores on the EPDS scale has been found to be effective in reducing depression levels in mothers (Cox and Holden 2003).

Holden *et al* (1989) demonstrated the effectiveness of listening visits by health visitors in a randomised controlled trial for women suffering from PND. The health visitors were trained in counselling skills that emphasised the importance of listening and empowering mothers in their own decision making. Significantly, more women recovered in the experimental group than in the control group.
A total of four listening visits are offered, takes place in the home, lasts for 50 minutes and are by appointment. Listening visits involve the principles of active reflective listening using a non directive counselling skills approach where mothers are encouraged to explore their own feelings and believe they are valuable. It increases self esteem and self confidence and helps the depressed woman to trust in herself as a mother. (Holden 1996, Seeley 2009)

Cunningham (2008) in her thesis found that listening visits that took place in the home allowed mothers to feel safe and this sense of control enabled mothers to better articulate their feelings. The non judgemental approach helped mothers to move on and make choices about their treatment and strengthened the PHN/ mother relationship.
Guilt is one of the most common symptoms of depression. One study found that being able to talk to a health visitor relieved feelings of guilt and enabled mothers to be able to confide in others (Holden et al 1989).

Role of PHN
The work of the PHN is based on the principles of primary health care that include equity, accessibility, empowerment and self determination (Hanafin 1997).
The role of the PHN involves meeting the curative and preventative nursing needs of her population. The PHN provides integrated health promotion / education and offers support to bereaved and troubled families. The PHN is accessible to all postnatal mothers and babies up to school age advising on all aspects of child health with a particular emphasis on supporting breastfeeding (DOHC 2000).

The Postnatal Depression Screening and Support programme.
In 2005 an informal community needs assessment was carried out by the PHN Health Promotion co-ordinator. An absence of community services for mothers with postnatal depression was identified. In October 2005, Pubic Health Nurses (PHNs) in an area of North Dublin were invited to receive two days training in the early detection of postnatal depression and listening skills. The training was delivered by a public health nurse, maternity psychiatrist and a counsellor. The training was designed to deliver a programme similar to that of health visitors in the UK.
Resources were considered in taking up the PND programme. Screening visits at 6 weeks for PHNs with an average of 6-8 births per month, would add 84 to 96 home visits and hours of work per year. This does not include hours for the necessary paperwork or travel time. In one UK study Health Visitors estimated that 33% of their work prior to starting a PND screening programme was already taken up with mothers with PND symptoms (Fuggle and Hayden 2000). Taking up this programme would allow PHNs formalise this work and adopt a

more visible and evidenced based approach in the detection and support of mothers with PND symptoms.
Following a series of change management workshops, in June 2007 a total of 16 PHNs from some of the north Dublin areas, volunteered to undertake a screening and support programme for the detection of mothers with PND symptoms on a pilot basis. Ongoing regular support for the PHNs was available via lunchtime workshops and contact with the PHN health promotion co-ordinator.
The programme involves screening all mothers in the PHN caseload for symptoms of PND using the EPDS scale. The first screening visit allows mothers to talk about their feelings.

EPDS score	**Low**	**High**	**Very High**	**Question 10 on Self Harm** ***'In the past 7 days ,the thought of harming myself has occurred to me'***	
1-11	No Intervention Needed			*Never*	Score **0**
12-19		Intervention Needed		*Hardly ever*	**1**
20-30			May need urgent referral	*Sometimes*	**2**
Table 1				*Yes, quite often*	**3**

Mothers with high scores of ≥12 points are then re screened two weeks later.
If the score remains high the PHN offers a total of four listening visits. If scores still remain high the mother is referred on for further professional support.
The EPDS scoring system is outlined in **Table 1**. Particular attention is paid to what mother scores on the last question on self harm (Q10) on the EPDS scale.

Self Harm
Youth suicide in Ireland is currently the fifth highest in Europe for the 15 – 24 year age group. Hospital A&E treatment for deliberate self harm is greatest for young women in the 15 – 24 year age group (HSE 2005). Skegg (2005) suggests that self harm in adolescents is a cry of pain rather than a cry for help, often coming from a difficult childhood that may have included sexual abuse or marital disharmony. Mothers with positive scores on Question 10 on the EPDS scale should be referred for expert help as soon as possible and their GP informed, preferably with mothers consent (Holden 1996).
One Irish study on the teen parents support initiative found what adolescent mothers valued most was support with parenting, information, support with education and training courses, and someone to talk to. Young mothers felt health professionals did not spend time or show much interest in their lives or how they were coping but were more focused on the baby (DOHC 2000).
Pathways of Care
Pathways of care established for mothers suffering from PND symptoms in North Dublin include PHN referral to the mental health midwife in one Dublin maternity hospital and maternity psychiatrists from the three Dublin Maternity Hospitals who were supportive of the referral system. GPs were informed of the screening programme by letter. It was important that PHNs screened mothers at 6-8 weeks postnatal to achieve *early* detection of symptoms in order to avoid prolonged maternal suffering and promote infant bonding. However screening done outside of these times would also be included in the evaluation.

Clinical Interview

Using the EPDS scale on it's own as a diagnostic tool has recently raised issues of there being many false positives and false negatives for depression (NICE 2007). Recent evidence suggests clinical interview (mood assessment) a diagnostic interview based on DSM 1V, is used in conjunction with the EPDS scale to help reduce the number of false positives on the EPDS score and for greater sensitivity and specificity in detection of PND symptoms. (NICE 2007).

During the year of screening some PHNs received additional training in clinical interviewing. Clinical interview is a set of 9 questions that is learnt off and used as additional verbal inquiry by the PHN in conjunction with the mother completing the EPDS score. A score of ≥ 5 points, which must be inclusive of one or two of the two key screening questions on low mood and lack of enjoyment is indicative of moderate to major depression. The use of clinical interview while having greater specificity and sensitivity also removes the need for a repeat EPDS screen two weeks later.

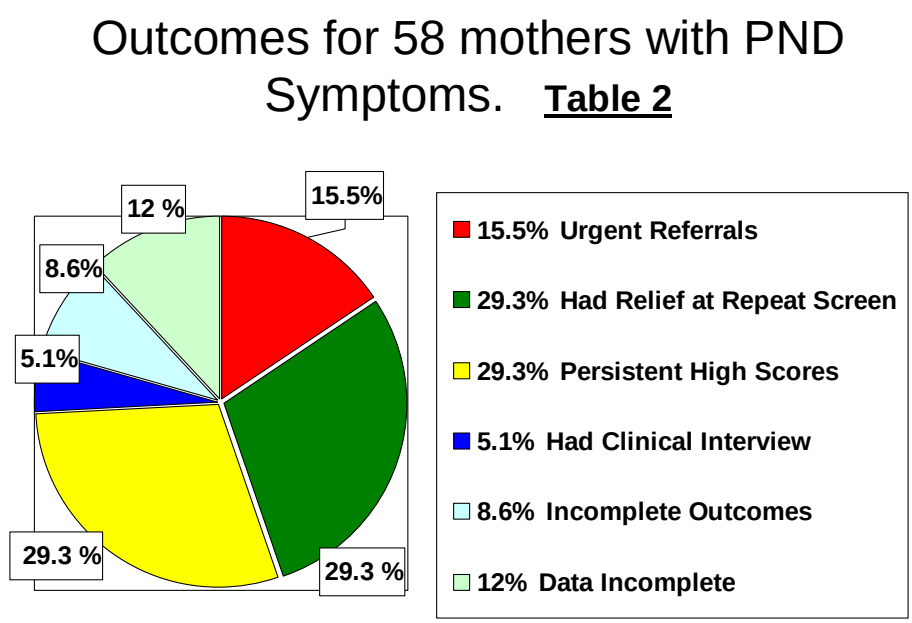
Data Results

PHNs agreed to record and return their data for a 12 month period for the purposes of auditing the programme, its effectiveness and to highlight findings. Mothers identity was coded at source by the screening PHN.

Data collated on Excel, found that PHNs returned data on a total of 718 postnatal mothers. Of these, 528 mothers consented for screening at home for PND using the EPDS scale. Data results and the findings are discussed together.

Of 528 mothers screened, 58 had a high score of ≥12 Points on the EPDS scale initial screen**.** This indicated a detection rate of 11% of mothers with PND symptoms.

Outcomes for 58 mothers with PND symptoms. **Table 2**



Urgent referrals for 15.5% (n=9) mothers (**SeeTable 3**)

15.5% (9) of very high score mothers were urgently referred by PHNs due to the severity of their symptoms. PHNs made their decisions based on the EPDS scores, self harm risk and PHNs own clinical judgement. PHNs made direct referrals to the pathways listed below. GPs were involved and / or informed by PHN letter.

Table 3 Weeks Postnatal	Mothers Age	EPDS Score	**Question 10 on** Self harm. Score	**Referrals** Community Mental Health Team (CMHT) Mental Health Midwife (MHM) Maternity Psychiatrist (MP)
6-8 weeks	16	22	2 (with a suicide plan)	GP, CMHT,MHM, Teen support group
6-8 weeks	18	17 rising to 27	1 rising to 3	GP, MHM, MP
8 weeks	20	26	2	GP, CMHNurse
19 weeks	21	21	3	GP, MHM, MP. Admission to A&E
1 week	22	26	0	GP, MHM, MP, Family support worker
8 weeks	21	20	2	GP, MP, Family support worker
6-8 weeks	27	20	2	GP MHM (Foreign National mother)
6 months	32	20+	0	GP, MP.
6-8 weeks	30	7	2	Native speaking GP for Foreign Nat mum

A total of 7 out of 9 mothers urgently referred by the PHN had thoughts of self harm occurring 'sometimes' or 'quite often' in the week prior to screening.

Young mothers with PND symptoms

Of mothers urgently referred, 66.6% (n=6) were in the 16 – 25 year age group, with 5 out of 6 mothers having thoughts of self harm occurring' sometimes' or 'quite often' in the week prior to screening. One 16 year old mother had a suicide plan.

The majority of mothers with self harm thoughts were in the adolescent to young adult age groups. This finding would tie in with the literature that shows self harm is more prevalent in women in younger age groups. As these mothers would have lifelong issues needing expert help beyond the scope of the PHN, these mothers were urgently referred, in most cases to the mental health midwife, and maternity psychiatrist.

An article in the Irish Medical Times reported recently that mental health services in Ireland for teenagers and young adults in this country is almost non existant (Gantly 2009). There is no expertise or professional field properly equipped to respond to young people in their early teens to mid-twenties. The development of better partnerships between primary and specialist care in developing youth-friendly environments would help to improve access to services for this age group (Gantly 2009).

PHNs may need to become more aware of how young mothers with mental health issues can access youth friendly community mental health services.

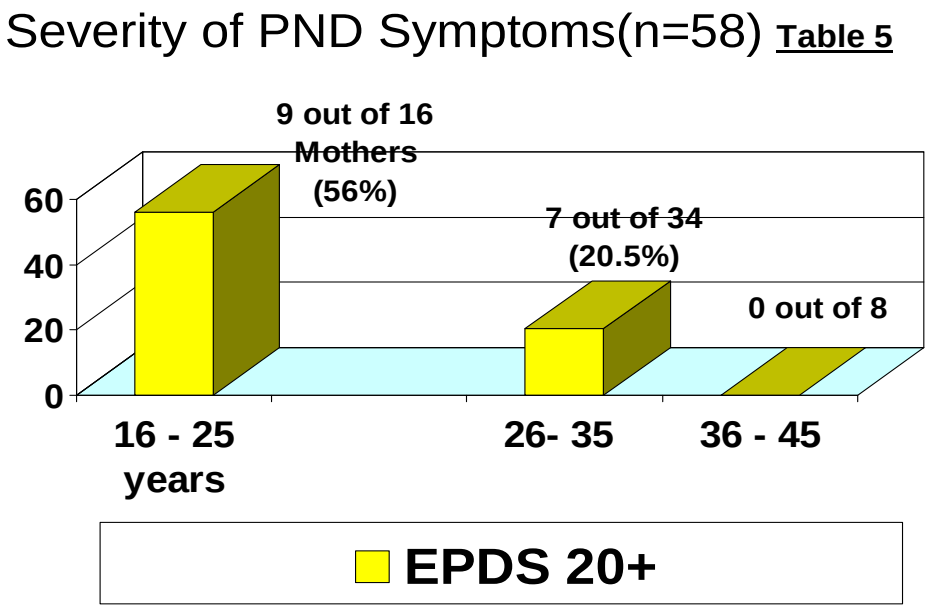
Occurrence rates of PND symptoms by age groups. **Table 4**

Table 4 Age	**16–25 years**	**26–34 years**	**36–45 years**	**No age data**	**Total**
No of mothers screened	123	307	80	18 mothers	528
PND symptoms	**13%**	**11%**	**10%**		

Table shows occurrence rates of PND symptoms to be just slightly higher in the 16-25 year age group.

Severity of PND symptoms according to age groups. **Table 5**

Severity of PND symptoms was greatest in the 16 – 25 age group.
A total of **56.3%** (n= 9 out of 16) high score mothers in the **16 – 25 year age group** had EPDS scores of 20+ and /or were positive for thoughts of self harm, in comparison to 20.5% (n=7 out of 34) of mothers in the 26-35 age group and 0% (n=0 out of 8) of mothers in the 36-45 age groups.



A student t- test was applied to the highest EPDS scores. Severity of PND symptoms was greater in the 16-25 year age group. This was found to be of statistical significance when compared to the 26 – 35 year age group. ($P > 0.04$. Confidence interval 96%)
Numbers were too small in the 36-45 year age group for comparison. The help of a full time statistician was used for this test.

Outcomes for **7** Mothers aged 16 and 17 years old**. Screened and not screened Table 6**

Age	Outcomes (Table 6)	Low scores	Not screened	Reason	Total
16	**1** suicide plan - referred	**0** mothers	**1** mother	Moved house	**2** mothers
17	**1** EPDS 20+ - disengaged	**3** mothers	**1** mother	Moved house	**5** mothers

Data returned on all mothers screened and not screened (n=718), revealed there was just 7 mothers that were aged 16 -17 years old. Reassurance was given in just 3 out of 7 mothers aged 16-17 years as having EPDS scores within the low range at 6-8 weeks postnatal.
Two out of 7 mothers had *very high* EPDS scores. One mother had a suicide plan and was being treated, while the other mother with a very high score disengaged with services. A further two mothers had moved house and did not receive a screening.

Summary on young mothers with PND symptoms

Findings show occurrence rates of PND symptoms to be just slightly higher in the 16-25 year age group. Severity of PND symptoms was greatest for mothers in the 16-25 age group in comparison to mothers in the 26-35 age groups and this finding was statistically significant. Reassurances could only be given in just 3 out of 7 mothers aged 16-17 years as having normal EPDS scores. One mother aged 17 years with a very high EPDS score disengaged with the PHN service.
PHNs may need to be more aware of the fragility of good mental health in adolescent and young adult mothers. Achieving better service reach, giving more time, creating a friendly, respectful and encouraging relationship, and the active promotion of youth supports like 'Teen Parents' early in the postnatal period may do much to help mothers in the adolescent age group. PHNs may need to become more aware of how young adult mothers with mental health issues can access youth friendly community mental health and support services.
A forum for young adult mothers to meet, antenatal as well as postnatal (aged 18 – 25 years approx) could be helpful and may need to be developed.

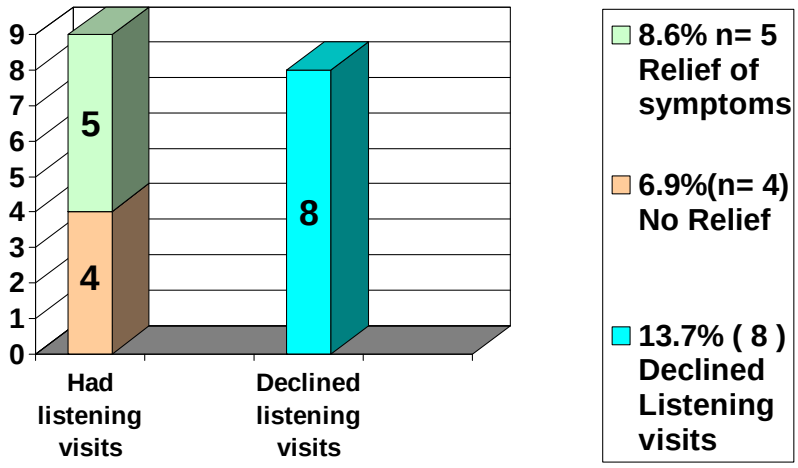
29.3% (n=17) of mothers got relief of symptoms from the screening visit.
The screening visit allows mothers to talk about their feelings. A total of 29.3% of mothers with high scores were found to have scores in the low range at the repeat screening visit two weeks later. The fact that so many mothers got relief of symptoms from the screening visit alone was unexpected. This is one of the main findings of the study. Similar findings were found in other studies.
Holden et al (1989) found that depressed mothers in their control group who did not receive health visitor listening visits got relief from just having their depression recognised at the screening visit and the opportunity to talk about their feelings.
Fuggle and Hayden (2000) state health visitors in their study found the benefits of the screening visit to depressed mothers to be one of the most valuable outcomes of their pilot project.
It could be said therefore that the initial screening visit achieved a valuable therapeutic intervention in itself for women with depression symptoms.

Outcomes for mothers with persistent high scores and listening visits. **Table 7**
A further 29.3% (n=17) of mothers had persistent high scores at the repeat screen two weeks later. Of these, 9 mothers received listening visits from PHNs of whom 5 mothers got relief of their symptoms. The 4 mothers who got no relief were referred on to other professional help.

13.7% (8) high score mothers declined PHN listening visits. Of these one mother with a very high score had just been recently bereaved and did not want visits. One mother with a high score who had self harm thoughts declined help.
Of the remaining 6 mothers, all had borderline high EPDS scores of between 12 -14 points of whom 2 mothers expressed difficulty coping with family / baby issues. Another two mothers were already attending mental health services, a fifth mother preferred to see her GP while the sixth mother said she felt better.

Outcomes for 29.3% (n=17) of mothers with persistent high scores

Table 7



There was a low number of mothers who received PHN listening visits. It was envisaged at the start of the programme that the number of mothers needing and taking up listening visits would be more. A similar finding was found in another health visitor study where listening visit uptake was lower than expected (Fuggle and Hayden 2000).
The reasons why high scoring mothers declined listening visits are varied.
The distinction between mothers struggling with other family life issues, anxiety around the baby, as opposed to PND symptoms as well as mothers own choice of treatment path need to be recognised. Possible false positives on the EPDS scale also needs to be recognised and is discussed in more detail in the next paragraph.

Possible false positives on the EPDS score

The number of mothers with false positive scores is difficult to identify. It's possible that some mothers who did not keep appointments for a repeat screen, may have been false positives on the EPDS score. It's also possible that mothers scoring 10 or 11 points on the EPDS scale can be false negatives. Screening PHNs in this programme detected 4 mothers with PND symptoms, who had scored only 10 and 11 points on the EPDS scale.

5.1% of mothers had clinical Interview.

Recent recommendations suggest that clinical interview (mood assessment) is used in conjunction with the EPDS scale for greater sensitivity and specificity in the detection of PND symptoms (NICE 2007) During the course of this study a small number of participating PHNs undertook additional training in clinical interviewing. One PHN implemented this in her practice and identified 5.1% (n=3) high score mothers who all scored 13 points on the EPDS scale as *not* having PND symptoms. As a result these mothers did not need a repeat screening visit.
It is envisaged that in the future PHNs will routinely use clinical interviewing in conjunction with the EPDS scale for greater sensitivity and specificity in detection of PND symptoms. The effectiveness and efficiency of PHN screening visits should also be increased.

Screening of mothers whose English was described as fair or poor.

A total of 9% (n=48) of mothers whose English was described as fair or poor were screened of whom 10.4% (n=5) mothers had high scores. Of these 3 mothers were urgently referred while two mothers had scores which returned to normal two weeks later. A large proportion of mothers in some PHN caseloads are foreign national mothers. PHNs used their own judgement in estimating mother's ability in speaking English, understanding and wish to be screened. The needs of mothers with PND symptoms whose English is fair or poor could be improved and that this group merits further attention.

Reasons for mothers not being screened. **Table 8**

Screened	**Not screened (Table 8)**							**Total**
Mothers screened	Language barrier	Staff resource issues	Declined a Screen	Did not keep app ointment	Moved house	Already on Rx for Depression	Blank Data	**190** not Screened
73.5% **(n=528)**	7.2% (n=52)	5.7% (n=41)	3.8% (n=27)	5.2% (n=37)	2.2% (n=16)	0.6% (n=4)	1.8% (n=13)	100% (n=718)

Language barrier (See table 8) excluded 7.2% (n=52) of mothers who did not speak English. The use of Interpreter services and the logistics of how this could be implemented for screening in the home in the community will need to be considered.
Another 5.2% (n=37) of mothers did not keep their appointment and 3.8% (n=27) of mothers declined the invitation to be screened. This programme is by consent only and mothers were not put under any pressure to complete the EPDS scale. It's possible that not keeping the appointment is another way of saying no to the invitation to be screened. Mothers were not offered a repeat appointment.

Mothers Evaluation of listening visits
PHNs were encouraged to invite their mothers who received listening visits to post in a brief, anonymous questionnaire evaluation of their listening visits using the SAE provided, to the health promotion co-ordinator.
A total of 6 mothers responded and all were very positive about their listening visits.. One mother wrote about being able to speak freely in the presence of a non judgemental listener. For another mother, it was the easy, understanding approach of the PHN, while another mother found having the service delivered in her own home to be of most value.

……it was really helpful to have people coming (to) my place(home).
……..(I) felt I could speak openly about my feelings without being judged.
..she (PHN) was very understanding...easy to talk with…

That PHNs were able to deliver a primary care service in early intervention for PND in the safe non stigmatising environment of the home is evident..
The above comments from mothers would suggest that therapeutic benefits were achieved and that mothers who responded were satisfied with the listening visits.

Evaluation by Public Health Nurses
A brief anonymous questionnaire completed by 50% of participating PHNs (n=8) in July 2009 favourably evaluated the programme. PHNs described the programme as rewarding, in giving time to listen to help mothers relieve their PND symptoms, and growing their competencies in how they approach mental health issues. Examples of their comments are:

…being able to give them time and to listen to them…relieves the situation.

..its rewarding work…mothers in distress are welcoming of support.

Would like to continue, feel I've built up a knowledge base and some confidence in approaching /screening for PND….

Public Health Nurses saw the benefits mothers received from the programme and the majority who responded wanted to continue with PND screening and support for mothers.
However PHNs also identified their own emotional drain, working with already vulnerable populations, working with mothers with mental health issues, time constraints and staffing levels as challenges within the programme.

…it can be draining as mothers here have some issue or another…it can be taxing on me..

…I feel it is very difficult due to workload with vulnerable families…I also find it difficult when faced with mothers with self harming thoughts..

Time constraints…not always having the time to devote to this very important service..

..I have reservations about whether I'll be able to continue (with the programme)... due to staffing issues…

Support for PHNS
The need for adequate training and ongoing support and evaluation for PHNs involved in PND screening and listening visits is highlighted here. It may be helpful for PHNs to develop their own resource PHNs, and have protected time for supportive clinical meetings on a regular basis to share experiences, build confidence and grow best practice.
Mental health advice readily available locally to screening PHNs may need to be strengthened. Nurse to nurse referrals and shared care did take place between the PHN and the CMHN attached to the primary care team for 4 high scoring mothers. Where this ability was available it was verbally reported as being valuable to mothers and particularly supportive to PHNs. The role of the hospital mental health midwife was also verbally regarded as being very supportive to Public Health Nurses.

Stigma
A total of 5.6% (n= 30) of mothers in this study scored 0 points on the EPDS scale. Scores of 0 points are suggestive of dishonesty in answering (Cox and Holden 2003). A further 19% (n=64) mothers declined a screening visit or did not keep their screening appointment. It's possible therefore that fear of stigma and being thought an unfit mother may still exist in relation to postnatal depression.
In mother's evaluation, one mother referred to stigma and a lack of understanding around PND and that more awareness was needed.

…More people (need to be) aware of PND as there is a lot of stigma and lack of understanding from husbands family and friends.

Awareness raising is an important health promotion activity (NAHB 2004). PHNs are well placed in increasing awareness of PND in the local community through screening and support.

In the PHN evaluation, one PHN felt one of the best things about PND screening was mothers getting to talk about it and women having their feeling heard and validated.

….'the fact that PND was spoken about'…..and women's feelings acknowledged

Another PHN felt screening was essential to help remove the stigma of depression

..'it has become an essential part of our caseloads(work) by…helping to destigmatise depression

This early intervention helped to get mothers talking and as a result 'normalised' mother's experiences of PND symptoms. It enables her to talk to others about it and seek further help.

Early intervention and Staff resource issues

A total of 58.9% of mothers were screened within the recommended 6-8 week postnatal period. This figure rises to 70% of mothers who were screened by 10 weeks postnatal. Just 1.2% (n=8) of mothers were screened at between 4-5 weeks postnatal.
Most PHNs described the programme and the paperwork involved as time consuming. Developing Clinical interviewing skills combined with reduced paperwork should help make the programme more effective and efficient in the future. In 2007 NICE brought forward their recommended screening periods to between 4 - 6 weeks and again at 3-4 months postnatal. The need for PHN staffing levels to be at best increased or at least maintained is essential if the programme is to be continued and developed according to best practice guidelines

Summary
A large proportion (29.3%) of high scoring mothers got relief of PND symptoms from the screening visit alone. The screening visit achieved a valuable therapeutic intervention in itself and was the main finding of the study. A similar finding was reported in other studies.

Severity of PND symptoms was greater for mothers in the 16-25 year age groups and this finding was statistically significant. PHNs may need to be more aware of the fragility of good mental health in adolescent and young adult mothers. Giving more time, creating a friendly, respectful and encouraging relationship, and the active promotion of supports like 'Teen Parents' early in the postnatal period may do much to help adolescent mothers. PHNs may need to become more aware of how adolescent mothers aged 15 – 17 years and young adult mothers aged 18 – 25 years with mental health issues can access youth friendly community mental health and support services, antenatally as well as postnatally.

The number of mothers with PND symptoms who received PHN listening visits was lower than expected. This was a finding in another health visitor study. The reasons mothers declined listening visits are varied and the issue of false positives on the EPDS scale needs to be considered. The use of clinical interview (mood assessment) in conjunction with the EPDS score is now recommended by NICE to increase sensitivity and specificity in detection of PND symptoms. It is envisaged that PHNs will use clinical interview in future screenings.

Listening visits were positively evaluated by mothers. Being able to talk freely without being judged, the easy understanding approach of the PHN, and that listening visits took place in the home was particularly valued. There is some evidence from this study that fear of stigma for mothers around postnatal depression may still exist.

PHNs saw the benefits mothers received from the programme and the majority of PHNs who responded wanted to continue with PND screening and support for mothers. The need for mental health advice to be readily available locally to screening PHNs may need to be strengthened. It may be helpful for PHNs to develop their own local resource PHNs, and have protected time for supportive clinical meetings on a regular basis to share experiences, build confidence and grow best practice.
The need for PHN staffing levels to be at best increased or at least maintained is essential if the PND screening and listening visit programme is to be continued and developed.

References

Cooper, P. J., Murray, L. (1998). Postnatal Depression. British Medical Journal 316: 1884 – 1886.

Cox, J, Holden, J. (2003). PerinataL Mental Health: - a guide to the Edinburgh Postnatal Depression Scale (EPDS). Gaskell Books: London UK.

Crotty, F., Sheehan, J. (2004). Prevalence and detection of postnatal depression in an Irish community sample. Irish Journal of Psychiatric Medicine. 21(4), P117 – 121.

Cunningham, AM. (2008). Thesis: Mothers experiences of listening visits by their public health nurse. School of Nursing, Dublin City University.

Health Services Executive. (2005). Reach out – National Strategy for Action on Suicide Prevention www.hse.ie

Department of Health and Children (2000). Circular 41/2000. Job Description of the Public Health Nurse. Dublin: DOHC.

Department of Health and Children (2000). Final evaluation report of the Teen Parents Support Initiative. Dublin.

Fuggle and Hayden (2000). Estimating resources for setting up an HV service for postnatal depression. (2000) British Journal for Community Nursing. 5 (7) p348 - 351

Gantly, D. (2009). Re-engineering Youth Mental Health. Irish Medical Times http://www.imt.ie/opinion/2009/09/reengineering_youth_mental_hea.html

Hanafin, Sinead (1997). The role of the Irish public health nurse: manager, clinician and health promoter. Health Visitor 70(1), 295-296.

Holden, Sagovsky and Cox (1989). Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. British Medical Journal Vol 298,P223 – 226.

Holden, Jeni (1996) Prevention, Detection and Management of Postnatal Depression – A Manual for Health Professionals. Greater Glasgow Health Board.

Health Services Executive (Dec 2006). Child Mental and Emotional Health: A Review of Evidence. Sligo: Population Health Directorate,. www.pacirl.ie or www.hse.ie

National Institute for Health and Clinical Excellence (2007). Antenatal and Perinatal Mental Health - the NICE Guideline on clinical management and service guidance. London: The British Psychological Society.

Northern Area Health Board (2004). Health Promotion for North Dublin City and County: Strategy and Action Plan. Health Promotion Service. Park House, Dublin 7

Scottish Intercollegiate Guidelines Network (2002). Postnatal Depression and Puerperal Psychosis - A National Clinical Guideline. SIGN Executive. Royal College of Physicians, Edinburgh. www.sign.ac.uk.

Seeley, S. (2009). Perinatal Depression: Detection and Management in Primary Care – an introductory handbook for use in the training programme (In house). University of Reading. UK

Shakespere,J., Blake,F., Garcia,J., (2003). A qualitative study of the acceptability of routine screening of postnatal women using the Edinburgh Postnatal Depression Scale. British Journal of General Practice. 53, p614-619.

Skegg, K (2005). Self- Harm. The Lancet, 366 (9495): 1471 – 1483.

Whooley,M.A., Avins, A.L., Miranda, J., et al .(1997) Case-finding instruments for depression. Two questions are as good as many. Journal of General Internal Medicine, 12, 439-445

Acknowledgements
Sincere thanks to Ms Marianne Healy, Director of Public Health Nursing, whose vision allowed this programme to happen. Sincere thanks to the Public Health Nurses in Wellmount, Roselawn, Mountview and Riverside Health Centres whose courage and hard work made this study come to life.