Use of the Hospital Anxiety And Depression Scale (HADS) within FNP: National Unit Clinical Guidance.

The approach towards mental health conditions within the Family Nurse Partnership programme is to collaborate with clients to both identify these and work towards their management with other specialist professionals. Research highlights that young parents are particularly susceptible to developing anxiety in pregnancy or the early antenatal period and that untreated maternal anxiety can impact on foetal brain growth and development, as well as raising cortisol in the child’s blood stream, affecting stress responses in childhood.

HADS\(^1\) is a validated assessment tool which is able to identify both anxiety and depression. The FNP NU pays a license fee for its use both at set points within the FNP programme and at additional points as necessary as part of a nurse’s further assessment of a client’s mental health. This guidance offers further information regarding expected practices in the use of HADS by FNP teams. Like all FNP National Unit guidance, it is recommended that each FNP site Advisory Board (FAB) considers the contents of this guidance in line with local clinical governance processes, agrees its adoption and any necessary local amendments/additions, and supports its integration into local clinical systems.

The purposes for use of HADS

1. To identify high levels of anxiety in pregnancy, because of the negative impact this can have on the developing foetus. Antenatal anxiety and/or depression are also good predictors of postnatal depression.

2. To identify high levels of depression and/or anxiety postnatally as we know it has a negative impact on the growing mother-infant relationship and the mother’s well-being and capacity to enjoy her new maternal role.

Protocol for using HADS

The family nurse should:

1. Work with the client to complete the HADS at Pregnancy visit 3 or 4. If this is not possible, attempt to have it completed as early as possible.
2. Repeat the use of the HADS postnatally, as close to 6 weeks as possible.
3. Ensure that the HADs scores, further assessment and actions to follow are recorded within the client's records.
4. Ensure that the two sets of scores (antenatal and postnatal) are added to the correct data forms to enable further population level analysis (see below).
5. Repeat the use of HADs whenever it is clinically indicated, or will assist with the nurse’s assessment of a client’s on-going mental health status.

Scoring and interpreting the HADS

The family nurse should:

1. Add up the depression scores (light green items)
2. Add up the anxiety scores (light blue items)
3. Consider her/his own professional assessment of the client’s mental health status based on observations and analysis of her behaviours, alongside the self-assessment provided by HADS. Consider carefully the meaning of any discrepancy between the two.
4. Use the guidance below to interpret the assessment and actions which should follow.
5. Use opportunities provided by supervision and psychological consultation to review decision making where the FN is in any doubt.

Indicative actions following a HADS assessment:

Whilst the HADs tool contains cut off points for the presence/possible presence and absence of clinically meaningful degrees of depression and anxiety, research into its use has resulted in some small variations. The guidance below on the cut offs is therefore an indicative guide and should be used alongside the family nurse’s clinical judgement about the clients mood.

1. A depression and/or anxiety score of below 7 or 8 means that depression or anxiety is unlikely. Discuss with the client and use your clinical judgement to determine if any actions are required.

2. A score of between 7/8 and 10 indicates mild depression or anxiety. You may wish to explore this further with your client and use your clinical judgement to determine any actions required, over and above those already part of the forthcoming planned programme visits.
3. A score of between 10/11 and 14 indicates moderate depression or anxiety. You will need to discuss the responses with the client as an opportunity to explore the nature of the anxiety and/or depression and to further assess her mental health, supporting her to access other services as appropriate.

As a family nurse, you will wish to consider the client’s mood in planning the content of your visits, in addition to any treatment she is receiving elsewhere. The following is offered as a guide to your decision making in these circumstances:

- If the client is in the pregnancy stage of the programme and her anxiety score is 11+, provide her with a relaxation CD, or other locally developed resources or methods for anxiety management (see note below) and offer her guidance on its/their use. If the depression score is 11+ use your clinical judgement, but continuing to agenda match programme content well, especially in relation to developing her self-efficacy, and reviewing how she is feeling at the next visit may well be sufficient.

- If the client is in the infancy stage of the programme and hence has caregiving responsibilities, you will need to assess the impact of her emotional wellbeing on her parenting capacity and potential impact on the child as well as herself. Use of DANCE and PIPE to support the client to provide sensitive and responsive caregiving to her child, despite her mental health issues, will ameliorate the effects of her depression for the child and may help to improve the client’s mood. If the client’s anxiety score is 11+ provide her with a relaxation CD, or other locally developed resources or methods for anxiety management (see note below) and offer her guidance on its/their use, bearing in mind the challenges she may have to relax when caring for a small baby.

4. A depression score and/or anxiety score of between 15 and above is high and indicates severe anxiety or depression. Scores of this level should, at a minimum, prompt a discussion regarding treatment with the client’s GP, who will need to be informed of this score. Ideally support the client to access mental health services. In addition, the family nurse should consider the client’s stage within the programme and her parental responsibilities in making further judgements about how she can assist the client by matching programme inputs to her specific needs as above.
**Suicidal thoughts**

During discussions with clients who have anxiety or depression, especially those with HADs scores of 15 or above, the FN should also assess whether the client is having any suicidal thoughts.

i. Questions which may help to elicit these could include:

- Have you had any recent thoughts of harming yourself?
- Have you had recent thoughts that you would be better off dead?
- Are there any times when you think that life might be too much to bear or might not be worth living?
- Do you ever feel so upset or so distressed that you might do something to hurt or harm yourself in some way?

ii. If client says yes to any of these the FN should clarify by asking questions such as:

- Have you ever acted on these thoughts?
- If so, do you have a plan or ideas about what you would do?
- Have you made any serious plans?

If the client answers yes to any questions in i and/or ii the FN should seek specialist mental health advice from the GP or a mental health service immediately.

**Further activities to support integration and use of HADS**

- Supervisors should plan to have ‘use of HADS’ as a topic for a psychological consultation and enquire about its use by nurses during supervision.
- FABs should consider any local integration issues arising from use of HADS, especially in relation to local pathways for perinatal mental health and develop protocols and additional information for other professionals unfamiliar with the tool as necessary.
- Use of HADS does not preclude the use of validated screening tools such as the EPDS or PHQ 9, if these are used locally, although consideration should be given to the burden on clients. HADS is used within FNP as an assessment tool for the client’s mental state and to support further work or referrals to improve outcomes for her and her baby. Although HADs is not a screening tool and is therefore not specifically recommended within the latest NICE guidance, it is a validated assessment tool and when used as recommended in this guidance it is

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2 ‘Antenatal and postnatal mental health’ (Dec 2014) NICE
consistent with the expectations of the NICE recommendations. FNP supervisors and teams are encouraged to think together about ways in which they support clients to alleviate anxiety, both in pregnancy and infancy.

Some sites have successfully used relaxation CDs with clients, but it is important to note that no one CD will be acceptable to, or help, all clients. Supervisors and teams are advised to also discuss local strategies to support clients with anxiety issues with their Psychological Consultant and seek guidance from them on relaxation/breathing techniques or any useful resources which may be available locally. The aim is to encourage the client to develop self-soothing strategies which will need to be tailored to individual clients.

**Recording the HADS score on the FNP Information System**

**In Pregnancy**
The HADs assessment score is recorded on the UK006 (Health Habits form), completed at 36 weeks. As the HADs assessment is undertaken at the 4th pregnancy visit, it is expected that the nurse will enter the score on the form at this point and save the form as ‘Incomplete’ (click on ‘Finish Later’). If a client is not available or is reluctant to complete the HADs assessment with the nurse, the nurse is expected to continue to revisit this with the client and use her clinical judgement to assess the client's mental health and take any appropriate action. If the HADs assessment is undertaken later, the scores can be saved on the UK006 any time up to 36 weeks. If for any reason, the HADS cannot be completed or the client refuses, the nurse needs to add a score of 99 within the HADs field and then the form can be saved as complete. Any form saved as ‘incomplete’ should be completed with the additional information at 36 weeks. Note - the HADs score can only be inputted on the 36 weeks version of the UK006 form. It is not possible to input the HADs score on the intake and 12-month versions (the HADs question is greyed out at these time-points).

**In infancy**
After completion of the HADs assessment at the 6th infancy visit, the nurse should input the data on the UK012A (6 weeks) Health Form. If for any reason, the HADS cannot be completed or the client refuses, the nurse needs to add a score of 99 within the HADs field and then the form can be saved as complete.

**Ad hoc use of the HADs assessment**
Nurses are encouraged to repeat use of the HADs assessment with clients, in addition to the expected scheduled times, whenever they feel it is clinically appropriate to do so.
The tool can also be used to assess maternal anxiety and depression in any second pregnancies the client experiences during her involvement with FNP (see ‘National Unit Guidance on the Management of the Healthy Child programme for the second child of a client enrolled onto the FNP programme’ for more information).

In these circumstances the HADs score is not recorded onto the FNP Information system, but should still be entered into the client’s clinical record.

**FNP National Unit**
August 2015