Reviewer’s report

Title: The prevalence and correlates of suicidal ideation identified by the Edinburgh Postnatal Depression Scale in postpartum women in primary care

Version: 1 Date: 25 March 2011

Reviewer: Heather Rowe

Reviewer’s report:

This paper reports on the prevalence of suicidal ideation assessed as endorsement of Item 10 on the EPDS in a community sample of women screened for recruitment to a RCT, and its prevalence, persistence and correlates at approximately 2, 4 and 18 weeks later in a subsample of women who scored > 10 on the EPDS at the first assessment. Validation of suicidal thoughts was provided by responses to items on the CIS-R in the subsample. This is an important paper but before it can be published, attention to the points outlined below is needed.

- Major Compulsory Revisions and Minor Essential Revisions

Is the question posed by the authors well defined?

Introduction

1. A clearer distinction between the unselected sample of women who completed the EPDS screening questionnaire and the sub sample of women who were followed up (those scoring EPDS >10) should be made in the research aims, which were otherwise clearly stated.

Are the methods appropriate and well described?

Methods

The methods are appropriate and generally well described but some further details are required:

2. In order to assess potential selection bias, further information about recruitment to the study is needed. How were eligible women identified? Were all eligible women sent an invitation pack by their GP? How were these records kept? How was consent to a home visit obtained? (The use of a flow chart here would assist the reader).

3. Follow up schedule: Follow ups were scheduled at 4 weeks later? Please add. Attention to the consistency with which the assessment times are described in the manuscript is necessary (eg Baseline/ Time 0; Screening/ Time-2). State assessment time points, including abbreviations if appropriate, in the methods.

4. Measures: Please describe the ways in which socioeconomic status was assessed and coded. For example Table 3 reports on education levels which are not meaningful to an international audience.

5. Measures end of first para: Should be “EPDS was completed…..and at both
follow-ups”? (not all)

6. The SF-12 measures physical and mental health status rather than a quality of life construct.

7. Quality of relationship. Please provide further information about the GRIMS – specific construct(s) assessed, psychometric properties, whether relevant population norms are available for comparison, and that higher score means poorer relationship functioning.

8. Statistical methods:
   a. Please separate data coding (e.g., definition of SI) and describe outcome measures (including specified assessment point) separately prior to describing statistical tests.
   b. The description of how agreement between CIS-R and EPDS will be assessed is unclear (“....tabulated the measures on their full scores”). In addition to this table, and notwithstanding the lack of “gold standard” comparison, it would be useful to calculate how many “cases” of SI (CIS-R) were correctly identified by the EPDS Q 10.
   c. Methods for calculation of attrition bias should be described earlier in the analysis section.
   d. Outcomes of regression analyses need clearer description (see point a) above).
   e. How was treatment allocation handled in the multivariate analyses?
   f. Given the claim in the discussion that “clinicians can therefore be reassured that treatment results in improvements in suicidality”, it would be useful to describe methods of an analysis to test for a treatment effect on outcomes.

Are the data sound?
Generally, but there are some omissions in the reporting

Results

9. Details of recruitment should be reported briefly here even if they have been reported previously for the RESPOND trial. How many women were invited to participate (invitation packs posted)? How many questionnaires were returned? How many women scored EPDS >10 and agreed to participate in a home visit? How many women were randomised and subsequently received treatment?

10. Please state the recruitment fraction and n(follow-up) at 4 and 18 weeks; significant predictors of loss to follow up. Please provide population comparison for socioeconomic data where possible, preferably in a table with statistical tests. This is especially important given the topic, the need to assess generalisability of the findings, and the author’s comment in the Discussion about the socioeconomic status of their sample.

11. 3.1 Prevalence and persistence of SI: Table 1 would be more interpretable if the row and column totals were included. Rather than repetition of the contents of the table in the text, a summary of the findings is preferable and should be provided.
12. 3.2 Validity of EDPS measure of SI: Please provide numbers of women who scored below EPDS 13 for whom DIS-R was not completed (see methods section in the manuscript where this is alluded to). What is the “dichotomised EPDS score? Where is it reported? “endorsed” is preferable to “report positively”. Again the meaning of text description of the contents of Table 2 is not entirely clear. Please summarise findings in the text.

13. 3.3 Correlates of SI: Table 3 Please add “in women scoring EPDS>10” to title, and add “N=253”. To what does EQ-5D refer (last line)? EPDS score is reported in text as remaining significantly associated with the outcome in multivariate analysis but it does not appear in the Table. Please correct this. SF-12 mental is significantly associated with the outcome in multivariate analysis and listed in Table 3 but is not mentioned in the text. Please correct this. Please summarise results in the text including the plain-language meaning of the (higher or lower) scores.

14. Associations between SI at baseline, SF-12 subscales and EPDS at 18 weeks. Table 4 would be more interpretable if all factors that were included in the analyses, including adjustments for treatment group, predictors of attrition as well as SI at baseline were listed.

Are the discussion and conclusions well balanced and adequately supported by the data?

Please see below

Discussion

15. Para 1: Please assess the representativeness of the sample and refer to comparison data to justify the claim that the study sample (not “population”) “included women with higher levels of socioeconomic deprivation than in the previous studies”.

16. This paragraph also states results of the univariate analyses. Please state the multivariate outcome (younger, + 3 children, SF-12 and higher EPDS); and emphasise that the findings are from a sample of women scoring EPDS>10 (not a representative community sample).

17. Given that there appears to have been no significant association between treatment allocation and outcomes, it is difficult to substantiate the claim that “clinicians can therefore be reassured that treatment results in improvements in suicidality”.

Are limitations of the work clearly stated?

Some further comment on missing data, representativeness of sample would enhance this.

18. Para 2: “This study is one of the largest studies of suicidal ideation…” add …in women in the postpartum period”?

19. The finding that SI was not associated with measures of mental and physical health in follow-up is unexpected and requires further comment. What explanations for this finding can the authors suggest? Does this finding contradict other reports in the literature?
Does the manuscript adhere to the relevant standards for reporting and data deposition?
Yes

Do the authors clearly acknowledge any work upon which they are building, both published and unpublished?
Yes it appears so

Do the title and abstract accurately convey what has been found?
Yes

Is the writing acceptable?
Yes.

Minor issues not for publication
Methods end of para 1: replace comma with full stop
Ref #5 “Arch” should be italics not bold.

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** Yes, and I have assessed the statistics in my report.

**Declaration of competing interests:**
I declare that I have no competing interests