Screening Pregnant and Postpartum Women for Depression and Anxiety

Frequently Asked Questions

Background

Perinatal Mood and Anxiety Disorders, including Postpartum Depression, are the most common medical complication associated with pregnancy and childbirth. It is estimated that, at minimum, 15 percent of pregnant and postpartum women, and an even higher percentage of women of low socioeconomic status, experience anxiety, depression or psychosis. If left undetected and untreated, these conditions can lead to serious health risks for the mother, can negatively affect the mother/child bond and the child's long-term physical, emotional and developmental health, and ultimately, can be devastating for families.

Edinburgh Postnatal Depression Scale Inpatient Screening Program Objective

Dignity Health will implement system-wide implementation of the Edinburgh Postnatal Depression Scale (EPDS) for Perinatal Mood and Anxiety Disorders (PMADs) risk screening.

What is the Edinburgh Postnatal Depression Scale?

The Edinburgh Postnatal Depression Scale is a set of 10 screening questions that can indicate whether a parent has symptoms that are common in women with depression and anxiety during pregnancy and in the year following the birth of a child. It has been utilized among numerous populations including U.S. women and Spanish speaking women in other countries.

How long has the EPDS been in use?

In 1987, the EPDS was developed at health centers in Scotland by John L. Cox, Jenifer M. Holden, and Ruth Sagovsky to identify depression in postpartum women. Poor validity for postpartum women on existing depression scales, such as the Anxiety and Depression Scale, prompted Cox and colleagues to develop the EPDS, a specialized 10-question screening tool.

Can the EPDS be used for antepartum patients?

Yes, the EPDS was originally used in the postpartum period only. Since then, numerous studies have validated its use throughout the perinatal period, including the first trimester and beyond.

Who should complete the scale?

Patients should be instructed about the use of the EPDS and provided information during the prenatal and postpartum periods.

- Most patients complete the scale without difficulty in less than five minutes.
- The patient underlines the response that is closest to how she has been feeling in the previous seven days.
- The mother should complete the scale herself, whenever possible.
- Those who need assistance due to limited literacy should be helped by their care team.

What should I do when a postpartum patient is in a non-OB Department?

The Nurse Manager, or designee, should have a process to identify postpartum patients admitted to non-OB Departments. PMADs education and EPDS screening and documentation will be completed by the Postpartum RN, including referral to Social Worker if indicated.

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What should I do when a postpartum patient has experienced fetal/neonatal loss?

The decision to use the EPDS for patients with fetal/neonatal loss will be at the discretion of the RN and/or the Social Worker (SW). If the decision is made to forego screening using the EPDS, the postpartum RN will document EPDS screening as “not applicable” and refer patient to SW. The SW will provide the patient with the *Maternal Health and Grief* brochure, assessment, referral and resources. If the patient is discharged prior to a Social Work assessment, education, including the *Maternal Health and Grief* brochure, will be provided by the postpartum RN.

What should I do when a postpartum patient has an infant in the NICU?

The EPDS documentation will be completed by the postpartum RN. The NICU RN will refer the mother to Social Work (SW).* The Social Worker will provide ongoing education regarding PMADs, and may choose to repeat screening as needed. If the infant is transferred out to another facility, the SW will communicate and collaborate with the SW at the facility where the infant is receiving care, as needed.

**Social Worker referral required by California Children’s Services (CCS) in CA.*

How is the risk assessment score calculated?

The EPDS consists of 10 short statements with four possible responses.

- The patient underlines the response that is closest to how she has been feeling in the previous seven days.
- Each question is scored with a 0, 1, 2, or 3.
- The maximum total score is 30.
- The higher a score is, the more likely the woman is experiencing some level of perinatal depression.

How are “at risk” patients identified?

The EPDS serves to guide best practices. However, the most essential best practices are recognizing the need to evaluate each patient individually and always utilizing sound clinical judgment. When piloting the EPDS in New York OBGYN offices, the ACOG District II task force used a threshold of 10 in an effort to identify many potential cases.

- Patients with a total score equal to or greater than 10 are considered “at risk”
- Question 10 on the EPDS tool addresses suicidal ideation. If a patient scores higher than zero (0) specifically on question 10, immediate action is needed.

How do I introduce the EPDS scale to my patients?

Patients may wonder why they are being asked to complete the EPDS. Pregnancy is supposed to be a joyous occasion. It is important for apprehensive patients to understand what perinatal depression is, to know that many women experience similar feelings and to realize that untreated perinatal depression may have adverse effects on women’s health and their children. The following suggested script has been used to reduce potential patient apprehension regarding the postpartum EPDS: “Now that you have had your baby, I would like to know how you are feeling and how you have been coping lately. Please take a few minutes to fill out this short survey.”

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How do I instruct my patients on using the scale?

The mother should complete the scale herself, whenever possible. If a problem arises, the care team must make a decision as to how to best administer the EPDS.

- The mother is asked to circle 1 of 4 possible responses that comes the closest to how she has been feeling the previous seven days.
- All 10 items must be completed.
- Care should be taken to avoid the possibility of the mother discussing her answers with others.

What if a patient speaks or reads a language other than English?

Patients may prefer to complete the scale in a language other than English.

- The EPDS form is currently available in English, Spanish Arabic, Armenian, Burmese, Chinese, Hindi, Hmong, Punjabi, Russian, and Vietnamese.
- For other languages, please contact the Perinatal Safety Team.

What do I do if the score is below 10 but I have some concerns about my patient's emotional state?

The most essential best practices are recognizing the need to evaluate each patient individually and always utilizing sound clinical judgment. If you have any concerns regarding the patient's emotional or psychological state:

- Provide education
- Notify Social Work and/or Chaplin services as needed
- Notify the patient's provider

What do I do if the score is 10 - 12?

If the risk assessment score is 10 - 12:

- Discuss results with patient and provide education
- Refer to Social Work
- Notify the patient's OB provider

What do I do if the score is 13 or higher?

If the score is 13 or higher:

- Discuss results with patient and provide education
- Refer to Social Work
- Notify OBGYN Provider immediately

What do I do if the score on Question #10 is higher than 0?

If the score for Question #10 is higher than 0:

- Refer to Social Work
- Notify OB provider immediately

References

1. Cox J.L., Holden J, M, and Zagosky R. (1987) Edinburgh Postnatal Depression Scale (EPDS) British Journal of Psychiatry 150, 782-786.
2. American Congress of Obstetricians and Gynecologists (ACOG), (2008). Perinatal Depression Screening; Tools for Obstetricians and Gynecologists. ACOG. Albany, New York 12210.