1. **PURPOSE:** To provide a guideline and tool to screen for perinatal and postpartum depression. The primary goal of this process is to identify women who may be at risk for or are suffering from depression or perinatal mood disorder.
2. **PATIENT POPULATION:** Neonate Infant Pediatric X Adolescent X Adult
3. **POLICY:**
   1. The Edinburgh Postnatal Depression Screen (EPDS) and the Postpartum Depression Risk Factor Questionnaire (PDRQ) are to be used as guides for best practice. The most essential best practice is recognizing the need to evaluate each patient individually and using clinical judgment. The EPDS and PDRQ score should never override clinical judgment. The EPDS and PDRQ are screening tools and do not diagnose depression.
      1. Any pregnant or postpartum patient who presents with signs or symptoms of depression will be screened using the EPDS and PDRQ.
      2. All postpartum patients will be screened using the EPDS and PDRQ prior to discharge.
      3. All Antepartum patients will be screened 2 weeks after admission and every 2 weeks until delivered or discharged from the hospital.
      4. Appropriate follow up and notification will be completed (see attached algorithm).
4. **PROCEDURE:** 
   1. Screener/RN will:
      1. Provide education and instructions to patients on how to complete the EPDS and PDRQ.
      2. Give the EPDS and PDRQ tools to the patient for completion on the day of discharge or time when screener feels most appropriate.
      3. Screener will score the tools.
      4. Refer to attached algorithm for interventions based on scores.
   2. EPDS/PDRQ
      1. If question 10 is 1 or higher on EPDS screen, ask patient if she is currently suicidal. Do not leave infant alone with mother. A hospital staff member should provide continuous observed care of infant at bedside until further plan of care is initiated (see hospital policy on Patients at Risk for Suicide, Care and Assessment).
      2. Notify social worker and OB provider.
      3. Document EPDS score in EMR and on PDRQ form.
      4. Document interventions in EMR.
      5. A copy of the EPDS and PDRQ form will go in the patient chart.
      6. A copy of the PDRQ (with EPDS score documented) will be sent to OB office and Pediatric office, if authorized with patient signature.
      7. A copy of PDRQ and EPDS will be placed in PMD screening designated file.
5. **EXCEPTIONS:**

This screening will not apply to Bereavement patients. Bereavement patients are to be followed up with by bereavement caregivers.

1. **DEFINITIONS:**
   1. EPDS- Edinburgh Postnatal Depression Scale (EPDS)-The 10 item self-report questionnaire was designed specifically for detection of depression in the postpartum period. Untreated PMD increases the risk for future episodes of major depression and can develop into a chronic depressive disorder.
   2. PDRQ- Postpartum Depression Risk Factor Questionnaire (PDRQ)-a self-administered screening tool that provides questions about individual risk factors for developing a PMD. It helps to identify new mothers who are at greater risk for developing a PMD. Based on the patients score, further follow-up may take place. The patient is requested to sign the screening assessment tool to authorize a permission to share screening results with her OB and Pediatric provider and for follow up phone call.
   3. PMD- Perinatal Mood Disorder (PMD)
   4. PMAD- Perinatal Mood and Anxiety Disorders (PMAD)-serious conditions that affect 10-20% of pregnant and postpartum women (1 in 6 women). The EPDS screening tool permits formal evaluation of changes in functioning such as sleep, appetite, and weight. Untreated PMD increases the risk for future episodes of major depression and can develop into a chronic depressive disorder.
   5. PPD- Postpartum Depression (PPD)
   6. PP Blues- 40-80% of postpartum women will develop postpartum blues which is a transient condition marked by mild and often rapid mood swings from elation to sadness usually occurring within 2-3 days after delivery. Symptoms usually peak on the 5th day after delivery and resolve within 2 weeks.
2. **REFERENCES:**
   1. Detection of postpartum depression: Development of the 10 item Edinburgh Postnatal Depression Scale (EPDS), British Journal of Psychiatry (1987), 150, 782-786. A. J.L. Cox, J.M. Holden, R. Sagovsky.
   2. Onset Timing, Thoughts of Self-harm, and Diagnoses in Postpartum Women with Screen-Positive Depression Findings. JAMA Psychiatry. May 2013; 70(5):490-498. Katherine L. Wisner, MD, et al.
   3. Psychosocial Risk Factors: perinatal screening and intervention. ACOG Committee Opinion No. 343. American College of Obstetricians and Gynecologists. Obstet/Gynecol 2006; 108:469-77.
   4. AWHONN Position Statement 2008; The Role of the Nurse in Postpartum Mood and Anxiety Disorders.
   5. PMD Support Program Development Toolkit, Spectrum Health Healthier Communities. Nancy Roberts RN, CCE, CBC Educator, Postpartum Emotional Support (2016). Grand Rapids, MI.

**Sierra Vista Regional Medical Center Postpartum Depression Screening Algorithm**

Postpartum Depression Risk Factor Questionnaire (PDRQ)

Edinburgh Postnatal Depression Scale (EPDS)

Screening Tool:

EPDS 12 or greater total score

PDRQ “YES” on #5, 6, 7, 8, 9, OR three or four “YES” on #1, 2, 3, 4,

EPDS 9-11 total score

EPDS 0-9 total score

PDRQ

All “NO” #1-9

PDRQ one or two “YES” on #1,2,3, or 4

**OR OR OR**

Bedside RN provides education on symptoms, risk factors and resources. Highlight PMD info in the New Beginnings book.

Document score in EMR.

Bedside RN provides education on symptoms, risk factors and resources. Highlight PMD info in New Beginnings book.

Bedside RN provides education on symptoms, risk factors and resources. Highlight PMD info in New Beginnings book.

Notify Social Worker & OB provider. Document interventions in EMR.

Notify Social Worker & OB provider. Document interventions in EMR.

**\*\*Place copy of EPDS/PDRQ in pt chart.**

**Fax copies to OB/Peds offices if authorized.**

**Follow up RN will place call to *moderate* &**

***high* risk patients 2-4 days after discharge**.

**\*Answers 1, 2, or 3 on #10 (in EPDS) regardless of score. Ask more questions. Currently suicidal?**



**Questionnaire/Authorization**

**POSTPARTUM DEPRESSION**

**RISK FACTORS QUESTIONNAIRE/**

**AUTHORIZATION FOR FOLLOW-UP**

**QUESTIONNAIRE**

Mothers feel a range of emotional reactions after giving birth, including baby blues and

postpartum depression or anxiety. Your answers will help identify your risk factors for these.

**YES NO**

**+** **–** 1. My mother or sister(s) have had postpartum depression or anxiety.

**+** **–** 2. During the past year, I have experienced a lot of stress and change, such as loss of a job or income, loss of a loved one, homelessness or other stressors.

**+** **–** 3. This was a **very** difficult pregnancy for me emotionally and/or physically.

**+ –** 4. This was a **very** difficult birth for me emotionally and/or physically.

**+ –** 5. I have a history of depression, anxiety or other mental health condition that was **not**

related to pregnancy or birth.

**+ –** 6. I had depression or anxiety for more than 3 weeks after another birth.

**+ –** 7. In the past year I have taken medicine for depression, anxiety or another mental

health condition.

**+ –** 8. I need more emotional support from family and friends.

**+ –** 9. I had depression or anxiety that I felt I needed help with during pregnancy.

**+ – \*I would like more information about postpartum emotional support before I leave**

**the hospital.**

Preferred phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of: My obstetric (OB) doctor/clinic**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

My baby's doctor/clinic**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

My mental health provider/therapist**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AUTHORIZATION**

\* I give permission to share these results with my health care providers.

Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name (**print**)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STAFF USE ONLY**

Risk Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Edinburgh Postanatal Depression Scale Score\_\_\_\_\_\_\_\_\_\_\_

Referrals\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Baby in NICU\_\_\_\_\_\_\_\_\_\_\_\_ Multiple Birth\_\_\_\_\_\_\_\_\_\_\_\_

*TIME:\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_ Staff signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OB care provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Delivery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**As you are pregnant or have recently had a baby,** we would like to know how you are feeling. Please CIRCLE the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

**Example:**

I have felt happy:

0 Yes, all the time.

1 Yes, most of the time

2 No, not very often

3 No, not at all

**In the past 7 days:**

1. I have been able to laugh and see the funny side of things:

0 As much as I always could

1 Not quite so much now

2 Definitely not so much now

3 Not at all

2. I have looked forward with enjoyment to things:

0 As much as I ever did

1 Rather less than I used to

2 Definitely less than I used to

3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong:

3 Yes, most of the time

2 Yes, some of the time

1 Not very often

0 No, never

4. I have been anxious or worried for no good reason:

0 No, not at all

1 Hardly ever

2 Yes, very often

3 Yes, very often

5. I have felt scared or panicky for no very good reason: 3 Yes, quite a lot 2 Yes, sometimes

1 No, not much

0 No, not at all

*Cox. J.L. Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. Bristish Journal of Psychiatry 150: 782-786.*

6. Things have been getting on top of me:

3 Yes, most of the time I haven't

been able to cope at all

2 Yes, sometimes I haven't been

coping as well as usual

1 No, most of the time I have coped

quite well

0 No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping:

3 Yes, most of the time

2 Yes, sometimes

1 Not very often

0 No, not at all

8. I have felt sad or miserable:

3 Yes, most of the time

2 Yes, quite often

1 Not very often

0 No, not at all

9. I have been so unhappy that I have been crying:

3 Yes, most of the time

2 Yes, quite often

1 Only occasionally

0 No, never

10. The thought of harming myself has occurred to me:

3 Yes, quite often

2 Sometimes

1 Hardly ever

0 No, never