Edinburgh Postnatal Depression Scale Tip Sheet

**Quick Facts about the Tool**


**Authors’ Intent:** Efficient way to identify patients at risk for perinatal depression to support follow-up and treatment, to promote appropriate treatment, and reduce risks for perinatal mood disorders.

**About the Tool:** 10 questions that ask pregnant women or women who have recently delivered a baby to select the answer that comes closest to how they have felt in the past 7 days.

**Purpose**

Postpartum depression is the most common complication of childbearing. The 10-question EPDS is an effective tool to screen for a depressive illness, and does address the anxiety component of perinatal mood and anxiety disorders (PMADs).

**Protocol**

- Be compassionate, open, and respectful when introducing the tool.
- Make sure that the person completing the EPDS can speak freely and safely.
- Ask the woman to check the response that comes closest to how she has been feeling the previous 7 days. All items must be completed.
- Care should be taken to avoid the possibility of the woman discussing her answers with others, and a woman should complete the scale herself unless she has limited English or limited literacy.
- A woman with a score of 13 or more is likely to be suffering from a depressive illness of varying severity. However, research encourages referring at a lower threshold score of 10, as this is an indication of "possible depression" and warrants the need for a compassionate conversation, closer attention, referral and follow-up. Across MCH services, we want to error on the side of caution, therefore **referral should be made at the lower cut-off score of 10**, indicating a positive screen.
- If a woman answers “Yes, quite often” or “Sometimes” to question 10, follow the "Crisis Intervention" algorithm provided in the associated toolkit.
- **Complete the screen at least once prenatally and in the postpartum period, but ideally more often as per timing guidelines provided in the associated toolkit.**
- Enter completed EPDS and referral in DAISEY. Document all follow-up.

**Pitfalls**

- The screen is not a diagnostic tool, and results should be shared clearly, stating that the results are NOT a diagnosis.
- Regardless of the score, a woman may still benefit from further evaluation (clinical judgment). She might be suffering but not relate/identify with the EPDS wording or be hesitant to be honest on the written tool.
- Don’t wait until you’re entering the data into DAISEY to determine if it is a positive or negative screen. Score it onsite and have a meaningful conversation about referral needs or signs to watch for as PPD can emerge during the first few days, weeks, or months post-birth.

Adapted by the Kansas Department of Health and Environment, Bureau of Family Health, from tip sheets created by Lilly Irvin-Vitela, 2014, on behalf of UW Milwaukee Child Welfare Partnerships and WI Dept. of Children and Families
Quick Facts

Postpartum Depression:  
Who experiences perinatal mood disorder?

- 10-13% of new mothers experience postpartum depression triggered by childbirth
- Postpartum depression usually begins 2 to 3 weeks after giving birth but can start any time during the first few days, weeks, or months post-delivery, as well as prenatally.
- U.S. fathers had nearly twice the rate of paternal prenatal and postpartum depression as fathers in other countries (Paulson & Bazemore, 2010).
- 10% of men exhibited elevated levels of depressive symptoms when their child was 9 months old compared to 14% of mothers (Journal of Child Psychology, 2008).

Symptoms of Postpartum Depression (NIMH):

- A woman with postpartum depression may feel sad, hopeless, worthless, or alone.
- She may have trouble concentrating or completing routine tasks.
- She may lose her appetite or not feel interested in food.
- She may feel indifferent to her baby.
- She may feel overwhelmed by her situations and feel that there is no hope.
- She may feel like she is just going through the motions of her day without being able to feel happy, interested, pleased, or joyful about anything.

Risk of Perinatal Mood Disorders (NIMH):

Women with one or more of the following risk factors may be at greater risk for developing postpartum depression:

- Depressive symptoms during or after a prior pregnancy
- Previous experience with depression or bipolar disorder at another time in her life
- A family member who has been diagnosed with depression or other mental illness
- A stressful life event during pregnancy or shortly after giving birth, such as job loss, death of a loved one, domestic violence, or personal illness
- Medical complications during childbirth, including premature delivery or having a baby with medical problems
- Mixed feelings about the pregnancy whether it was planned or unplanned
- A lack of strong emotional support from her spouse, partner, family, or friends
- Alcohol or other drug abuse problems

Usefulness to Practitioners

- Identifying potential depressive disorders and connecting mothers to resources can be pivotal in supporting positive change and the reduction of risks in vulnerable families.
- Screening can build trust and strengthen partnership if the mother feels supported.
- Choosing parent education strategies: When postpartum depression impacts a mother’s thinking and feelings, simplifying goals becomes even more important to build trust and a mother’s self-confidence.
- Routine and repeated practice of skills that a mom shows some interest in are important in making progress and maintaining engagement.
- Maintaining regular visits and communicating between visits is even more important as a stabilizing force when a woman is experiencing symptoms of depression, such as feelings of worthlessness and loneliness.
- Helps to contextualize family goal setting:
  - Understanding the mothers’ mental health can provide insight into child development and parent-child attachment.
  - Gives insight to home visitors about barriers families may be experiencing in meeting goals. A mother may have difficulty with problem solving and follow through while depressed.

Follow-up Resources

National Women’s Health Information Center  
www.womenshealth.gov

Postpartum Support International  
www.postpartum.net

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Tips for Supervisors

Preparation
Understand How Scoring Works and Make Sure Staff Understand Too:
- Questions 1, 2, and 4 are scored 0, 1, 2, or 3 with the top box scored as zero and the bottom scored as a three.
- Questions 3, 5-10 are reverse scored with the top box scored as a three and the bottom scored as a zero.
- Maximum score is 30.
- Possible depression 10 or greater; indicates need for referral.
- Always look at item 10 regardless of other responses.
- EPDS cut-off is 2 points lower for men (Journal of Affective Disorders, 2001 May).

Recruiting MCH Staff:
- Let potential MCH staff know that screening for depression and discussing screening results are part of the job responsibilities.
- Give candidates a few minutes to review the EPDS and then ask them to role play administration of the EPDS and sharing results during the interview.

Orienting MCH Staff:
- Discuss the amount of perinatal mood disorders in the general population and in the program.
- Describe the impacts of depression on parent-child bonding.
- Schedule attendance at a "Mental Health First Aid" training within the first 6 months of employment. Go to https://www.mentalhealthfirstaid.org/take-a-course/find-a-course/ for training dates and locations near you.
- Provide multiple role play opportunities within the first 90 days of employment.
- The first time administering the screen should not be with a home visiting family.

Reflection
- Discuss feelings and reactions to administering the EPDS with MCH staff during staff meetings and/or during one-on-one supervision.
- Listen without judgment.
- The supervisor and staff should discuss the implications of the EPDS results on service delivery and add ideas to case notes.
- Identify staff who are comfortable and effective in delivering the EPDS, and pair them with colleagues to practice skills.

Administration
- Monitor completion of the EPDS and documentation of referrals for positive screens in DAISEY.
- Monitor for documentation of results and follow-up notes.
- Analyze data to see if there are any trends.

Reflective Exercises

During MCH Visits
- Ask open-ended questions about what the woman thinks the score means. Also ask questions like “are there any concerns about your mental/emotional well-being that we have not covered today?”
- Affirm the woman’s ability to think carefully about her own well-being. Ask her to share ideas she has about how her own well-being can affect her child’s well-being.
- Explore the woman’s ambivalence about follow-up.
- If concern about the possibility of postpartum depression persists, balance sharing concern with conveying confidence in the woman’s abilities:
  - Encourage the mother to seek support.
  - Emphasize that depression is treatable.
  - Provide support to positive interactions with a child including active modeling, coaching.
  - Avoid warning, shaming, or pushing for follow-up.
  - Develop a safety plan in which the mother identifies how she will know if she needs more help.
- Ask the mother to explore friends and family who she trusts and may be available to spend time regularly with the infant/toddler to boost positive interactions and provide support.

After the MCH Visit
- Communicate regularly with your supervisor to determine if greater intervention is in order.
- Document follow-up.
- During group reflective practice, explore strategies with colleagues to engage the mother in positive interactions with the child.

“BECAUSE CHRONIC AND SEVERE MATERNAL DEPRESSION HAS POTENTIALLY FAR-REACHING HARMFUL EFFECTS ON FAMILIES AND CHILDREN, ITS WIDESPREAD OCCURRENCE CAN UNDERMINE THE FUTURE PROSPERITY AND WELL-BEING OF SOCIETY AS A WHOLE.”

~CENTER ON THE DEVELOPING CHILD, HARVARD UNIVERSITY

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