3.8 Resources/Tools/Guides

3.8.4 Edinburgh Postnatal Depression Scale (EPDS) - Guidelines for use

Introduction

Parental perinatal mental health issues have a significant impact on the parent/carer, their partner, and other family members. They also impact the infant because of the potential disruption to the development of a safe and secure parent/carer-infant relationship. Infant mental health refers to the impact parent/carer mental health and the social context of the family have on the biological, cognitive, social, and emotional development of the child, both short and long term.

Postnatal Depression is a term used to describe a sustained depressive disorder which is more prolonged than the ‘blues’ (which may occur in the first week after childbirth) but less severe than puerperal psychosis. The point prevalence of perinatal depression in the postnatal period is approximately 13 percent of mothers and one in ten fathers.1, 2 Additionally, 25 to 50% of men with postnatal depression will have partners with perinatal depression, anxiety, or another mood disorder.3

For some women, mental health issues may begin during pregnancy and continue through to parenthood, and even beyond through later pregnancies if left untreated.4 The point prevalence of perinatal depression for women is currently estimated to be 7-12 percent in the antenatal period.1 For this reason the term Perinatal Depression is used to recognise the onset of depression at any time from conception to thirty-six months after birth.

Infant mental health is significantly impacted by the mental health of parents/carers. Exposure to chronic anxiety in utero can increase the risk of prematurity and low birth weight in the infant as well as complications in labour.5 The relationship between the parents/carers and their infant plays an important role in the mental health and development in the child. Symptoms of perinatal anxiety disorders and depression, such as persistent worry, lethargy, withdrawal from social contact, and feelings of hopelessness, may lead parents/carers to be less responsive and emotionally available to their infants.6 This can lead to an insecure attachment, 4, 5 which, in the long term, can reduce language acquisition, school performance, mental development, and emotional regulation.7

The Edinburgh Postnatal Depression Scale (EPDS) was developed in 1987 by Cox, Holden and Sagovsky as a self-report questionnaire and is today used in many countries to screen for the risk of developing perinatal depression. The EPDS is a 10-item screening questionnaire that is easy to administer and score and has
demonstrated high reliability and specificity.\textsuperscript{8} The EPDS has been validated across several cultures and countries for detection of perinatal depression. It has been translated into 36 different languages, 18 of which have been validated by research according to specific criteria. The remainder have been translated but not validated. Each language version has a unique recommended cut-off score.

There is a unique cut-off score for men who speak English. A score above the cut-off indicates that depressive symptoms may be present and that further clinical assessment is required. Community Child Health Nurses (CCHNs) need to be familiar with the specific cut off scores when offering an EPDS to men or to non English speaking women. The EPDS is also being used to screen for depression during the antenatal period as well as for anxiety and suicide risk, with cut-off scores for the anxiety subscale on questions 3, 4 and 5.\textsuperscript{9}

Changes were made to the timing and cut off scores of the EPDS in the 2010 review based on evidence that was current at the time,\textsuperscript{10} and have been kept in the current policy. Based on consultations with perinatal mental health specialist CCHNs, child health specialists from Princess Margaret Hospital (PMH), representatives from the WA Perinatal Mental Health Unit (WAPMHU), and the latest research, it is recommended that the EPDS be offered to both of the parents/carers postnatally, and whenever the opportunity presents itself antenatally. This is to be done where there is parental or professional concern and the ability to offer the tool in accordance with the guidelines and instructions set out below. Specific emphasis has also been included around the anxiety subscale as it has demonstrated utility to CCHNs in detecting anxiety.\textsuperscript{9} See “Instructions for using the EPDS with parents/carers” below for details of the timing and cut off of the EPDS and the anxiety subscale.

Benefits for using the EPDS

- Administering the EPDS provides a safe way to open up communication with the parents/carers about emotional issues. It encourages parents/carers to talk about any issues whilst providing an opportunity for detection of risk and early intervention.

- The EPDS increases awareness and knowledge among health professionals, parents/carers, and their families of the possibility of developing perinatal depression and anxiety.

- It provides the opportunity for additional information to be given to parents/carers when making referrals and provides a universal language between health care professionals that facilitates referrals.

- It can be used in conjunction with a psychosocial assessment to provide a more holistic picture of the potential issues parents/carers and their families might be facing.

- Uses a structured approach to:
Identify and clarify symptoms of depression and anxiety as indicated by the client’s perception of their mood

Monitoring outcomes of treatment.

General guidelines for using the EPDS

- The EPDS should only be used by CCHNs who have been trained in its use and have a clear referral pathway. Training should include suicide risk assessment and management.

- The EPDS should be used as an indicator of the risk of depression and anxiety NOT as a diagnostic tool. It helps CCHNs identify those who need to be monitored or referred for further assessment.

- It should be used in conjunction with sound clinical observation of the parent’s/carer’s interaction with the CCHN and attachment to the infant to assist with the care plan and/or referral plan (refer to the Department of Health Attachment pamphlet under “Resources for Parents/Carers”).

- The scale provides an indication of the parent’s/carer’s perception of their mood in the preceding 7 days. It does not predict on-going mood.

- CCHNs should be aware of a client’s life events and recent stressors, such as job loss or bereavement, because these stressful events might produce a high EPDS score but they might not indicate distress.

- The EPDS should be offered in an environment where the staff member and parent/carer have privacy. It should not be used in an open clinic setting, over the telephone, or posted to parents/carers.

- The EPDS should be offered opportunistically at any point in the perinatal period, conception to 36 months post birth (in accordance with the other general guidelines and instructions) where there is professional or parental concern as well as access to appropriate support services.

- Literacy level (in any language), cultural background, and language difficulties should be considered before using the EPDS so that appropriate arrangements can be made e.g. obtaining the assistance of an interpreter or Aboriginal Health Worker.

- If an interpreter is required, it is best practice to use a professional interpreter as the presence of a partner and/or other relatives may influence the parent’s/carer’s responses.

- It is possible anxiety disorders are more common than, and just as detrimental to infant and parental health as, perinatal depression and therefore it is important the anxiety subscale is used by CCHNs in conjunction with a psychosocial assessment and clinical judgement.
Instructions for using the EPDS with parents/carers

- The child health centre or a home visit may provide suitable opportunities for the completion of the EPDS.

- The EPDS must be offered postnatally to all mothers or primary carers on at least two occasions after the birth of the baby:
  - 6-8 weeks
  - 3-4 months
  - Any other time where there is parental or professional concern.

- The EPDS should be offered to fathers or secondary carers attending the clinic.

- The parent/carer is asked to underline the response which comes closest to how he or she has been feeling in the previous 7 days.
  
  Note: it is essential that the correct form is used. The layout of the form must require clients to underline their response. When clients underline their response, they are more committed to their answer. Versions of the EPDS with tick boxes are not validated for use. The current English version of the EPDS form is available on the CACH birth to school entry website in Resources/tools/guides, 3.8.4.1.

- All ten items must be completed.

- Any mismatch between the EPDS score and the clinical presentation should be explored further.

- The scale should be completed by the parent/carer personally unless the parent/carer has limited English (and a relevant translation is not available) or has difficulty with reading.

- The health professional should discuss the parent’s/carer’s responses one by one, being alert to clinical presentation.

- For parents/carers who have a first language other than English, a resource titled Using the Edinburgh Postnatal Depression Scale (EPDS) translated into languages other than English contains 36 translated versions of the scale and the appropriate cut off scores for each (see Resources for Professionals below).
Scoring the EPDS

- CCHNs should score the EPDS on completion and discuss the parent’s/carer’s responses one by one. The screening tool is used in conjunction with good clinical judgement, clinical observation of the client’s interaction with the infant and the staff member, and a psychosocial assessment.

- Questions 1, 2, & 4 are scored 0, 1, 2, or 3 with the top response scored as 0 and the bottom response scored as 3. Questions 3 and 5-10 are scored in reverse, with the top response scored as a 3 and the bottom response scored as 0.

<table>
<thead>
<tr>
<th>Q 1&amp; 2</th>
<th>Q 3</th>
<th>Q 4</th>
<th>Q 5-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

- The maximum score on the EPDS is 30. Consult the Perinatal Mental Health Clinical Referral Pathway for referral options. This pathway enables CCHNs to consider appropriate local resources and referral options. The Clinical Referral Pathway is available on the CACH website within policy, procedures and guidelines, birth to school entry, Resources/tools/guides, 3.8.4.2.

- A score of 0 is considered unusual, may indicate masking or literacy issues and requires further discussion with the client.

- See “Interpreting the score” for the English version cut-off scores from men and women.

- **Anxiety:**
  - Subscale on questions 3, 4, & 5
  - Total score of 9
  - Irrespective of the overall EPDS score, a score over 6 for women and over 4 for men may indicate the presence of anxiety, and further clinical assessment is required.

- **Suicide Risk:**
  - Question 10 on the EPDS
  - A score of 1, 2 or 3 requires a more detailed assessment regarding current risk of suicide or self harm (including: intent, plan, method, impulsivity, recent events, etc)
  - Recheck that these feelings occurred in the last 7 days.
Interpreting the score

The antenatal cut-off score for women is 14 or above. The following are postnatal cut off scores for English speaking men and women.

Note: the scores in the table apply to the English version. If a translated version of the EPDS has been used, refer to the additional notes for that specific language version to determine the appropriate cut-off scores.

### For women:

<table>
<thead>
<tr>
<th>Score</th>
<th>Risk of perinatal depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>Low risk</td>
</tr>
<tr>
<td>10-12</td>
<td>Moderate risk</td>
</tr>
<tr>
<td>13 - 30</td>
<td>High risk</td>
</tr>
</tbody>
</table>

### For men:

<table>
<thead>
<tr>
<th>Score</th>
<th>Risk of perinatal depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>Low risk</td>
</tr>
<tr>
<td>6 or more</td>
<td>High risk</td>
</tr>
</tbody>
</table>

Follow up and Service Planning

- Discuss the results with the client and their partner or family member/s if clinically relevant and agreed to by the client.
- Reflect on the client’s clinical presentation, their psychosocial assessment, and their responses to the EPDS when developing a care and referral plan.
- Further assessment including a risk and self-harm assessment may be required.
- Develop a plan of care with the parent/carer as per the Perinatal Mental Health Clinical Referral Pathway and include frequency of contacts and referrals needs.

The Perinatal Mental Health Clinical Referral Pathway indicates the types of services that might be helpful to parents/carers. It enables CCHNs to consider their own appropriate local services and referral options. CCHNs will need to ensure that culturally appropriate services are provided to parents/carers where they are available e.g. provision for CaLD parents/carers, Aboriginal and Torres Strait Islander parents/carers, single parents/carers, young parents, and men.

Documentation

- All EPDS scores, notes on clinical presentation, and the psychosocial assessment, along with any other relevant findings, are to be recorded in the appropriate electronic or paper based records. This may include Child Health Record CHS 560, or the Family Health Record CHS 560B.
For results within the normal range, record the result in the CHS 560 and/or in electronic records where relevant.

Where there is a high score, or a positive response to question 10, document findings in the appropriate electronic or paper based records, according to local area health service guidelines and use the same format to document all subsequent care delivered regarding parental mental health.

Retain a copy of the parent completed EPDS in the client record, for the purpose of future comparisons of results and to meet legal requirements regarding the medical record.

Management Strategies

Refer to the Perinatal Mental Health Clinical Referral Pathway for further detail.

### AT MODERATE RISK OF PERINATAL DEPRESSION

<table>
<thead>
<tr>
<th>Individual Support</th>
<th>Active listening. Discussion of feelings, experiences, role change, changes in relationship, and losses and gains.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support Networks</td>
<td>Encourage enlisting support from GP, partner, family, and friends. Encourage participation in new parent groups. Where appropriate and available, consider enlisting a social worker.</td>
</tr>
<tr>
<td>Time IN</td>
<td>Teach and encourage parents to have regular time-in devoted to positive interactions with the infant.</td>
</tr>
<tr>
<td>Time OUT</td>
<td>Encourage regular weekly time-out e.g. with child care services or partner or friends looking after child.</td>
</tr>
<tr>
<td>Information</td>
<td>Booklets on perinatal mental health and other take-home resources.</td>
</tr>
<tr>
<td>Follow-up</td>
<td>Repeat in one month.</td>
</tr>
</tbody>
</table>

### AT HIGH RISK OF PERINATAL DEPRESSION

**Use strategies for moderate risk of perinatal depression in addition to:**

<table>
<thead>
<tr>
<th>Assess risk of suicide &amp; harm</th>
<th>Assess harm to self or harm to baby. Explore any thoughts or intentions of harm to self or to the baby.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral &amp; liaison</td>
<td>As per referral pathway. Refer to GP for a care/referral plan. Discuss local agencies which provide support systems.</td>
</tr>
<tr>
<td>Support networks</td>
<td>Ensure support is available and that support people understand and recognise signs of perinatal depression and anxiety. Consider family and friends, and suggest participation in perinatal depression support groups.</td>
</tr>
<tr>
<td>Time IN</td>
<td>Teach and encourage parents to have regular time-in devoted to positive interactions with the infant.</td>
</tr>
<tr>
<td>Time OUT</td>
<td>Ensure frequent time out e.g. with child care services or partner or friends looking after child.</td>
</tr>
<tr>
<td>-------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Treatment options</td>
<td>Discuss the range of options available, including counselling and anti-depressants. Encourage the client to take medication if it has been prescribed and to return to GP if they have concerns or questions.</td>
</tr>
<tr>
<td>Information</td>
<td>Ensure relevant local mental health services, information, and contact details are provided to client and support networks.</td>
</tr>
<tr>
<td>Debrief</td>
<td>Be aware of own feelings and debrief with someone suitable (e.g. colleagues).</td>
</tr>
<tr>
<td>Follow up</td>
<td>Repeat EPDS in 2-4 weeks.</td>
</tr>
</tbody>
</table>

Resources for Professionals

The following resources represent a selected few that CCHNs may access for their clinical practice and continued education.


- **WA Perinatal Mental Health Unit**

- Using the *Edinburgh Postnatal Depression Scale (EPDS) Translated into Languages Other than English*.

- Boodjarri Business: Working with Aboriginal Mums, Babies and Families
  A DVD guide for health professionals working with Indigenous families in the perinatal period.

- Boodjarri Business: Maternal Mental Health Resource for Aboriginal Health Workers
  This booklet, along with the training module, assists Health professionals working with Aboriginal parents during the perinatal period.

- Perinatal Depressive and Anxiety Disorders (Guidelines), King Edward Memorial Hospital - State wide Obstetric Support Unit.

- **Beyond BabyBlues:**
  This link allows CCHNs to download or order Beyond BabyBlues resources.

- EPDS Wheel.

- Perinatal clinical practice guidelines - Executive summary: A guide for primary care health professionals.
- Psychosocial assessment and management of perinatal mental health disorders: A guide for primary care health professionals.

**Resources for Parents and Carers**

The following resources represent a selected few that CCHNs may access to provide to their clients.

*Department of Health, WA:*
  - [Pregnancy: A-Z listing of Health Topics](#)
  - [Attachment (pamphlet)](#)

*WA Perinatal Mental Health Unit:*
  - Finding help before and after baby arrives
  - Boodjarri Business: Yarning about feelings after baby (DVD - Indigenous)
  - You Are Not Alone: Emotional Health for Mothers (DVD - Sudanese, Ethiopian, Iraqi)
  - More than the blues: Understanding postnatal depression (DVD).

*Beyond BabyBlues:*
This link allows parents to download or order Beyond BabyBlues resources.
  - Emotional Health during Pregnancy and Early Parenthood
  - Managing mental health conditions during pregnancy and parenthood: A guide for women and their families
  - Hey Dad & contact card - Contact Card is a companion item
  - Understanding perinatal depression and anxiety.

**Further Information**

*Mental Health:*
  - [Post Ante Natal Depression Association](#): PANDA provide a wide range of perinatal mental health services including: a helpline, education, and training.

  - [Children of Parents with a Mental Illness (COPMI)](#): COPMI provide information and resources for children and parents who experience a mental health issue. They also have a range of resources for health professionals assisting these families.

  - [Centre for Clinical Interventions](#): Self directed modules around depression, anxiety, worry, and other mental health issues.
• **Men’s Advisory Network:**
  MAN links men and boys into organisations, services, and information targeted at improving men’s and boy’s health, wellbeing, and connection with health services.

• **Lifeline:**
  Ph: 13 11 14
  Lifeline provides access to crisis support, suicide prevention, and mental health support services.

• **HealthInsite**

**Lifestyle and Parenting:**

• **Parenting WA**

• **Meerilinga Dads in the Early Years:**
  A father focussed set of resources and services to assist men with parenting issues in the early years.

• **Ngala:**
  Ngala’s principle aim is to provide and promote a range of services and programs, such as information on sleeping, feeding and infant development, that help families develop resilience, life skills and their own resources to enjoy an independent and fulfilling family life, including information for Fathers.

**Services**

WA Perinatal Mental Health Unit
King Edward Memorial Hospital
15 Loretto Street
Subiaco, WA 6008
(08) 9340 1795.

**Supporting and/or Related Policies**

• 3.3 Guidelines for Birth to School Entry Universal Contact Schedule
• 3.5.3 Perinatal and Infant Mental Health.
References


