Screening and Follow Up for Postpartum Depression: How to Improve Practice

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Significance of Problem

Affects 1 in 7 women during reproductive years
(ACOG, 2018)

Most frequently underdiagnosed complication
(RNAO, 2018)

Lack of proper screening in women’s healthcare settings
(Austin & Hight, 2017; Kendig et al., 2017; Learman, 2018)
PICOT Question/EBP Model

Among women who are 2- to 6-weeks postpartum (P), how does the implementation of a screening tool (EPDS) and follow up protocol (I) in a women’s health care setting affect screening rates and detection of postpartum depression (O), compared to current practice (C), over a 19-week period (T)?
Review of Literature

- **Key terms:** Postpartum depression, screen*, detect*, diagnos*, obstetric*, “primary care”, “primary health care”, and “primary healthcare”
- **Inclusion Criteria:** Published within last 5 years, peer-reviewed, English language, female gender
- **Exclusion Criteria:** Published in non-English language, focused primarily on treatment/prevention for postpartum depression, did not include women in the postpartum period, focused on depression in fatherhood

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Decision to Change Practice

Screen for depression at 2- or 6-week postpartum visit using EPDS tool

Discuss treatment with EPDS score ≥10 and rescreen in 2- to 4-weeks

Follow protocol for screening and management of postpartum depression

- ACOG (2018)
- Austin & Hihget (2017)
- Che Abdullah (2019)
- Edwards MPhil (2020)
- Learnman (2018)
- Maurer et al. (2018)
- O'Connor et al. (2016)

- Austin & Hihget (2017)
- Edwards MPhil (2020)

- Kendig et al. (2017)
Implementation

• Setting: Women’s health clinic in Northwest Indiana
• Sample: Women visiting the clinic for a 2- or 6-week postpartum visit
• Tool: Edinburgh Postnatal Depression Scale (EPDS)
• Intervention: Administer EPDS and demographic form to all postpartum women who consent to participate in the project along with a patient education handout for more information on postpartum depression; repeat screening in 2- to 4-weeks if EPDS score ≥10 and discuss treatment options per protocol
• Duration: 19 weeks
• Outcome: effect on screening rates and detection of postpartum depression and how demographic variables affect EPDS scores
Edinburgh Postnatal Depression Scale (EPDS)

Name: ___________________________ Address: ___________________________
Your Date of Birth: ___________________________ Phone: ___________________________
Baby’s Date of Birth: ___________________________

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

Here is an example, already completed.

I have felt happy:
- Yes, all the time
- Yes, most of the time This would mean: “I have felt happy most of the time” during the past week.
- No, not very often
- No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. I have looked forward with enjoyment to things
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, never

4. I have been anxious or worried for no good reason
   - Yes, most of the time
   - Yes, sometimes
   - Yes, quite often
   - No, not at all

5. I have felt scared or panicky for no very good reason
   - Yes, quite a lot
   - Yes, sometimes
   - No, much
   - No, not at all

6. Things have been getting on top of me
   - Yes, most of the time I haven’t been able to cope at all
   - Yes, sometimes I haven’t been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not at all

8. I have felt sad or miserable
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

9. I have been so unhappy that I have been crying
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

10. The thought of harming myself has occurred to me
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never

Understanding and Managing Postpartum Depression

- What is postpartum depression? Postpartum depression is a common mood disorder that can occur up to 1 year after giving birth

- What are symptoms of postpartum depression?
  - Depressed mood and/or agitation
  - Decreased pleasure/interest in activities
  - Significant weight loss or weight gain
  - Difficulty sleeping at night or sleeping too much at night/during the day
  - Fatigue or decreased energy
  - Feelings of hopelessness or worthlessness
  - Recurring thoughts of death or suicide

- How can you manage postpartum depression at home?
  - Exercise
    - Walking, yoga, light weight training, bicycle rides, swimming once bleeding has stopped
  - Time for self
    - Ask for help from partner/family/friends
    - Write in a journal
    - Read a book
    - Rest when the baby is napping/sleeping
  - Support from peers
    - Talk to and spend time with family and friends, seek help or advice from peers

- What are suicidal thoughts/being suicidal?
  - Recurrent thoughts of death or harming yourself
  - Thinking about a plan to carry out the act of suicide
  - Having the means to carry out the act of suicide (gun, pills, etc.)

- What to do when you are having suicidal thoughts
  - Tell your doctor/nurse practitioner if you are at the office
  - Call the National Suicide Prevention Lifeline number: 1-800-273-8255 or text the Crisis Text Line by texting HELLO to 741741
  - If you plan to attempt suicide, call 911 immediately
Demographic Characteristics/Data Analysis

- Demographic characteristics collected on postintervention group
  - Education level, marital status, job status, social history
- Demographic characteristics between groups
  - Age: independent $t$-test determined no statistically significant difference in ages ($p = .793$) between preintervention and postintervention groups; mean age 30 years old
  - Race: chi-square test determined no statistically significant difference in races ($p = .112$) between the preintervention and postintervention group

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Data Analysis/Evaluation

- Primary Outcome:
  - Measured as a frequency
  - 2.6% of women screened with EPDS in preintervention group
  - 52.9% of women screened with EPDS in postintervention group
  - 50.3% increase in screening rates using EPDS
• Secondary Outcomes:
  • Detection rates of postpartum depression:
    • Measured by an EPDS score of $\geq 10$
    • 100% increase in detection rates of postpartum depression using EPDS
  • Demographic variables and EPDS scores:
    • Mann-Whitney Test used
    • Age was statistically significant ($p = .048$) when looking at positive screenings (EPDS score $\geq 10$)
    • Women in their mid 30s had the highest EPDS scores of 11 and 18
    • Variables of education level, job status, race, marital status, and social history were not statistically significant.
Conclusions/Limitations

• **Conclusions:**
  - Use of the EPDS tool is feasible, cost-effective, and simple
  - Implementation of this EBP project increased screening/detection rates by using a valid/reliable screening tool (EPDS)
  - Following a protocol allows for consistent and effective screening and management of postpartum depression
  - Findings from this EBP project are consistent with the literature

• **Limitations:**
  - Staffing issues
  - COVID-19 impact
  - Reliance on staff to recruit participants
  - Concurrent recruitment of participants and project implementation
Recommendations

• **Recommendations for Future EBP Projects:**
  • Assess staff adherence and environmental factors
  • Separate recruitment of participants from project implementation

• **Implications for Practice:**
  • Women’s health clinics should screen all postpartum women for depression using an evidence-based screening tool
  • Protocols should be in place for screening and management of postpartum depression

• **Implications for Research:**
  • Further research on risk factors for postpartum depression
  • Further research on the use of the EPDS in women’s health clinics
Acknowledgments

- Dr. Chris Paquin (project advisor)
- Staff and providers at women’s health clinical site
- Nicholas Matusik (husband) and family
Screening and Follow up for Postpartum Depression: How to Improve Practice

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Significance of Problem

- Postpartum depression is one of the most common mental health conditions, affecting 1 in 7 women during their reproductive years (ACOG, 2018).
- There is a lack of proper screening for postpartum depression in primary care and women’s health care settings (Austin & Hight, 2017; Kendig et al., 2017; Learman, 2018).
- Healthcare providers, especially those in women’s health care settings, can participate in evidence-based screening and follow up care protocols for postpartum depression.

Review of Literature

- Key terms: Postpartum depression, screen*, detect*, diagnosis*, obstetric*, “primary care”, “primary health care”, and “primary healthcare”.
- Inclusion Criteria: Published within last 5 years, peer-reviewed, English language, female gender.
- Exclusion Criteria: Published in non-English language, focused primarily on treatment or prevention of postpartum depression, did not include women in the postpartum period, focused on depression in fatherhood.

PICOT Question

Among women who are 2 to 6-weeks postpartum (P), how does the implementation of a screening tool (EPDS) and follow up protocol (I) in a women’s health care setting affect screening rates and detection of postpartum depression (O), compared to current practice (C), over a 19-week period (T)?

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Best Practices

- Screen for postpartum depression at the 2- or 6-week postpartum visit using the EPDS screening tool.
- Follow up if EPDS score >10 to rescreen in 2- to 4-weeks and discuss treatment options according to protocol.
- Treatment should include alternative therapies such as cognitive behavioral therapy, exercise, time for self, and support from peers/family and pharmacologic treatment including sertraline and escitalopram when deemed necessary.

Implementation

- Setting: Women’s Health Clinic in Northwest Indiana
- Sample: Women visiting the clinic for 2- or 6-week postpartum visit.
- Tool: Edinburgh Postnatal Depression Scale (EPDS).
- Intervention: EPDS tool and demographic form administered, and participants given patient education handout with information on postpartum depression; repeat screening in 2- to 4-weeks if EPDS score ≥10 and discuss treatment options per protocol.
- EBP Model: Johns Hopkins Nursing Evidence Based Practice Model (JHNEBP).
- Duration: 19 weeks.

Conclusions and Recommendations

Conclusions:

- Use of the EPDS tool is feasible, cost-effective, and simple.
- Implementation of this EBP project increased screening/detection rates of postpartum depression by using a valid/reliable screening tool (EPDS).
- Following a protocol allows for consistent and effective screening and management of postpartum depression.

Recommendations for Practice:

- Women’s health clinics should screen all postpartum women for depression using an evidence-based screening tool.
- Protocols should be in place for screening and management of postpartum depression.

Secondary Outcomes:

- Detection Rates of Postpartum Depression: Depression was detected in two participants in the postintervention group compared to one in the preintervention group. Therefore, a 100% increase in detection rates of postpartum depression was seen as a result of project implementation.
- Demographic Variables and EPDS Scores: Age was a statistically significant variable (p = 0.048) affecting whether the participant had a positive screening (scored >10 on EPDS). Women in their mid 30s had the highest EPDS scores of 11 and 18. The variables of education level, job status, race, marital status, and social history were not statistically significant.

Acknowledgments: Dr. Chris Paquin (advisor), staff and providers at women’s health clinical site, Nicholas Matusik (husband).
References


